

A Thesis Submitted in Partial Fulfilment of the Registration for the Degree of
Doctor of Clinical Psychology at the University of Birmingham

Volume I: Research Component

**Literature review – “What Does Existing Evidence Reveal about the Causes
of Abuse and Neglect in Adult Residential Care Services? A Systematic
Review”**

**Empirical paper – “Making Sense of Varying Standards of Care: Front-
line Staff Experiences of Working in Residential Care Environments for
Adults with Learning Disabilities”**

Andrew John Hutchison

August 2014

Department of Clinical Psychology
School of Psychology
University of Birmingham
Edgbaston
Birmingham
B15 2TT
United Kingdom

UNIVERSITY OF
BIRMINGHAM

University of Birmingham Research Archive

e-theses repository

This unpublished thesis/dissertation is copyright of the author and/or third parties. The intellectual property rights of the author or third parties in respect of this work are as defined by The Copyright Designs and Patents Act 1988 or as modified by any successor legislation.

Any use made of information contained in this thesis/dissertation must be in accordance with that legislation and must be properly acknowledged. Further distribution or reproduction in any format is prohibited without the permission of the copyright holder.

Acknowledgments

I would like to express my gratitude to the following people who have supported me with the research component of this thesis. First and most importantly to my supervisor, for her expertise and guidance throughout. It has been great to have had the opportunity to learn from someone with so much research and clinical experience in this area. I would also like to thank James for his help with recruitment, and the participants themselves for sharing their experiences so openly. Thanks also to the additional members of staff from the Clinical Psychology Department at The University of Birmingham, who have assisted me with general enquiries along the way. Finally, thanks to my family and friends for their never ending support, especially Katie, for letting me drink so much of her tea.

Thesis Overview

This thesis is submitted in part fulfilment of the requirements for the degree of Doctorate of Clinical Psychology (Clin.Psy.D) at the University of Birmingham. The thesis is comprised of two volumes, which detail all research and clinical work conducted during training.

This Volume contains three research papers. The first of those is a literature review that examines what existing research evidence reveals about the causes of abuse and neglect in adult residential care services. The second paper is an empirical study, which adopts Interpretive Phenomenological Analysis (IPA) to examine front-line staff members' experiences of working in residential care for people with learning disabilities. Finally, the first volume contains a public domain briefing paper, which provides an overview of both the literature review and empirical paper in a manner suitable for dissemination to relevant stakeholders.

Volume II contains five Clinical Practice Reports (CPR) completed over the course of training. The reports each present a piece of clinical work carried out during placements in the specialties of Adult Forensic Mental Health, Child and Adolescent Mental Health, Learning Disabilities and Older Adult Mental Health. CPR 1 presents a cognitive-behavioural and psychodynamic formulation of a 34 year old male forensic service outpatient, with mood related difficulties. CPR 2 presents a service evaluation, which examines the application of clinical supervision for nursing staff within a Forensic Mental Health Service. CPR 3 presents a single-case experimental design that evaluates a cognitive-behavioural intervention for obsessive-compulsive difficulties, experienced by a 15 year old boy referred to Child and Adolescent Mental Health Services. CPR 4 presents the case of a 54 year-old woman referred to Community Learning Disability Psychology Services for bereavement related difficulties. Finally, CPR 5 was presented as an oral presentation and describes the case of a 79 year-old

woman referred to community older adult psychology services for trauma related difficulties.

The abstract relating to CPR 5 is presented in this thesis.

Contents

| | |
|---|------|
| Acknowledgments | ii |
| Thesis Overview | iii |
| Contents | v |
| List of Tables | viii |
| List of Figures | viii |
| 1. Literature Review | 1 |
| 1.1 Abstract | 2 |
| 1.2 Introduction | 3 |
| 1.3 Method | 6 |
| 1.3.1 Review Protocol | 6 |
| 1.3.2 Sources | 7 |
| 1.3.3 Procedure | 8 |
| 1.3.4 Study Quality Assessment | 9 |
| 1.4 Results | 10 |
| 1.4.1 General Sample Characteristics | 11 |
| 1.4.2 Contextual Characteristics | 11 |
| 1.4.3 Study Design Characteristics | 16 |
| 1.4.4 Findings: Causal and/or Risk Factors Identified | 16 |
| 1.4.5 Study Quality Assessment | 20 |
| 1.5 Discussion | 25 |
| 1.5.1 Theoretical Implications | 26 |
| 1.5.2 Applied Implications | 28 |
| 1.5.3 Limitations and Future Research Directions | 29 |
| 1.6 Conclusion | 31 |
| 1.7 References | 33 |

| | |
|--|----|
| 2. Empirical Paper | 38 |
| 2.1 Abstract | 39 |
| 2.2 Introduction | 40 |
| 2.3 Method | 43 |
| 2.3.1 Methodology | 43 |
| 2.3.2 Sampling Strategy | 43 |
| 2.3.3 Participants | 44 |
| 2.3.4 Procedure | 44 |
| 2.3.5 Interview Process | 45 |
| 2.3.6 Analysis | 46 |
| 2.4 Results | 47 |
| 2.4.1 Theme 1: Degree of Positive Relationship Reciprocity | 47 |
| 2.4.2 Theme 2: Value Congruence and Intrinsic Motivation | 53 |
| 2.4.3 Theme 3: Experiences of Environmental and Organisational Constraints | 56 |
| 2.5 Discussion | 58 |
| 2.5.1 Theoretical Implications | 58 |
| 2.5.2 Implications for Practice | 62 |
| 2.5.3 Limitations and Future Research Directions | 64 |
| 2.5.4 Reflections on the Researcher's Role in the Process | 65 |
| 2.6 Conclusions | 66 |
| 2.7 References | 68 |
| 3. Public Domain Briefing Paper | 72 |
| 3.1 Introduction | 72 |
| 3.1.1 What is this about? | 72 |
| 3.1.2 Why was this research done? | 72 |
| 3.2 Literature Review | 72 |
| 3.2.1 What is a literature review? | 72 |

| | |
|---|----|
| 3.2.2 Why was it necessary to conduct this review? | 72 |
| 3.2.3. What was the aim of the literature review? | 73 |
| 3.2.4 How was the review conducted? | 73 |
| 3.2.5 What did the review reveal? | 73 |
| 3.2.6 What conclusions were drawn from the review? | 74 |
| 3.3 Research Paper | 74 |
| 3.3.1 Why was this piece of research done? | 74 |
| 3.3.2 What was the aim of this research? | 75 |
| 3.3.3 How was this research conducted? | 75 |
| 3.3.4 What was found? | 75 |
| 3.3.5 What conclusions were drawn from this study? | 76 |
| Appendices | 77 |
| Appendix A: Instructions to Authors from Nominated Journals | 78 |
| Appendix B: Empirical Paper | 79 |
| Appendix B.1: Confirmation of Ethical Approval Email | 79 |
| Appendix B.2: Participant Information Sheet | 80 |
| Appendix B.3: Consent Form | 82 |
| Appendix B.4: Interview Schedule | 84 |
| Appendix B.5: Extract from Annotated Transcript | 85 |
| Appendix B.6: Extract from Analytical Process Document | 91 |

List of Tables

| | |
|---|----|
| Table 1.1 Summary of Cross-paradigm Framework of Trustworthiness and Rigour | 10 |
| Table 1.2 Study Characteristics | 12 |
| Table 1.3 Quality Indicators for Quantitative Studies | 22 |
| Table 1.4 Quality Indicators for Qualitative Studies | 24 |
| | |
| Table 2.1 Overview of Sample Characteristics | 44 |
| Table 2.2 Summary of Themes Relating to Front-line Staff Experiences of Their Role | 47 |

List of Figures

| | |
|---|---|
| Figure 1.1 Study Selection Process | 8 |
|---|---|

1. Literature Review

What Does Existing Evidence Reveal About the Causes of Abuse and Neglect in Adult Residential Care Services? A Systematic Review

1.1 Abstract

Recent high profile cases of substandard care and abuse in residential and inpatient health and social care settings for adults have raised serious concerns regarding the appropriateness of existing care provisions and practices. An emerging body of research literature reveals that attempts have been made to understand the possible causes and risk factors associated with substandard care and abuse in residential services. However, to date no attempts have been made to rigorously review and synthesise existing research evidence. Therefore, the aim of this paper was to conduct a systematic review of empirical research on causal and risk factors associated with abuse and neglect in residential care facilities. To synthesise and critically appraise the diverse range of research approaches and methods utilised, the review protocol incorporated quality criteria outlined by Sale and Brazil (2004), which advocates a cross-paradigm framework of trustworthiness and rigour. Searches identified 17 papers, reporting on 15 separate studies, which met the inclusion criteria for this review. Results revealed that research in this area has utilised a diverse range of methodological approaches to explore abuse and/or neglect within the context of residential services for older adults and adults with learning disabilities. Causal and risk factors identified were separated into those that operated at a cultural or organisational/environmental level and those that operated at an individual or interpersonal level. General study characteristics are presented, alongside relevant design characteristics/methodological quality indicators. Results are discussed in terms of their theoretical and applied implications and potential future research directions are identified.

Keywords: Causes, Abuse, Neglect, Residential Care, Adults

1.2 Introduction

Until relatively recently it was widely accepted that the complex care needs of specific groups of people (e.g. people with learning disabilities, people with severe and enduring mental health problems and older adults), were best managed in large scale residential institutions (Thane, 1978) and segregation from mainstream society was actively encouraged. However, since the 1980's the health and social care sector has adopted a more inclusive stance and placed greater emphasis on the need to support and care for people at home or in the community (Care Quality Commission: CQC, 2012a). Despite this, residential care homes and long-stay inpatient environments remain a feature of many health and social care services. Today's residential services represent specialist care environments for those with the most complex care needs, which necessitate intensive residential support. However, recent high profile cases of substandard care and abuse in residential and inpatient health and social care settings for adults (e.g. Department of Health, 2012) have raised serious concerns regarding the appropriateness of such care provisions and practices. Moreover, recent reports have revealed that many in-patient environments and residential care homes are failing to meet basic care and safeguarding standards. For example, in 2012 a national (UK) inspection and review of learning disability services revealed that almost 50% of hospitals and care homes did not meet national standards (CQC, 2012b). A similar review of older adult care homes also highlighted considerable variation in the standards of care being provided (CQC, 2012c).

Although the prevalence of sub-standard care appears to have been well documented in the research literature, neglectful and abusive practices continue to occur in care home and inpatient environments. Abuse has been defined as a violation of an individual's human and civil rights by any other person or persons (DH, 2000) and may be physical, verbal or psychological in nature; it may consist of a single act or repeated acts; and it may also be an act of neglect or an omission to act. Within the learning disability literature, a 2010 review of

adult protection data revealed that approximately one third of adult protection referrals related to people with learning disabilities (Beadle-Brown, Mansell, Cambridge, Milne & Whelton, 2010). Of those 63% were found to be living in residential care and the most frequently reported perpetrators were members of direct care staff (Beadle-Brown et al., 2010). Thus, prevalence figures suggest that people in residential care environments are more likely to be victims of abuse compared to those living in their own homes. While these figures are likely to be susceptible to reporting bias (i.e. instances of abuse that occur at home may be less likely to be reported), this provides compelling evidence to suggest that some specialist residential care environments are not protecting potentially vulnerable people from experiences of abuse or neglect.

Within the older adult literature, an international review of the prevalence of elder abuse and neglect revealed that one in six professional carers report committing psychological abuse and one in ten physical abuse (Cooper, Selwood & Livingston, 2008). In addition, it revealed that over 80% of care staff had observed abuse. Consequently, available self-report data suggests that abuse and neglect represents a common feature of carers' work experiences. In the UK, recent high profile media reports and serious case reviews have also highlighted the on-going existence of cases of abuse and neglect in a number of specialist care homes for older adults (e.g. Flynn, 2012; Sheather, 2011). A comparison has also been made between different care settings (i.e. nursing home care, paid home care & assisted living), which revealed that nursing homes have the highest rates of all types of abuse and that a move from paid home care to nursing home care could more than triple the odds of a person experiencing neglect (Page, Connor, Prokhorov, Fang & Post, 2009). Consequently, existing research and media evidence highlights an on-going need to provide better care and protection for many adults living in specialist care home environments with complex care needs.

An emerging body of literature documents attempts that have been made to understand possible causal factors associated with abusive care environments and substandard care practices. For example, Moore (2001) conducted a selective literature review on the abuse of adults with learning disabilities by those employed to care for them. The review adopted a conceptual framework identified by Sobsey (1994), which considers causal factors under three main headings or levels: the wider culture, the specific care environment, and the relationship between carer and the person being cared for. Based on the selective literature identified, Moore (2001) concluded that historic and current cultural beliefs/attitudes towards people with learning disabilities can contribute to the threat and likelihood of abuse. In addition, the design and operational systems of specific services were also identified as key predictors of abusive environments. For example, large impoverished environments, isolated services and the lack of a strong philosophy of care were all identified as factors that may facilitate and legitimize the occurrence of abuse. Finally, based on the literature reviewed, Moore (2001) suggested that the lack of a valuing relationship between carer and the person with a learning disability greatly increases the likelihood of abuse or neglect. The paper concludes by emphasising that the key to prevention may lie in understanding the attitudes beliefs, value systems and philosophies of staff, and the factors that shape those, rather than a focus on organisational structures and processes.

Similar causal influences have also been identified within the older adult literature. For example, a descriptive literature review of causes and risk factors associated with elder abuse identifies the following causal categories: the sociocultural climate; the caregiving context; the characteristics of the caregiver and the nature of the caregiving relationship (Jones, Holstege & Holstege, 1997). However, a recent review has raised questions about the quality of much of this research material (Daly, Merchant & Jogurst, 2011). Specifically, the review demonstrates that research in this area is dominated by observational/descriptive studies and

case study evidence. In addition, much of the available evidence within the older adult literature focuses on those living in the community, as opposed to residential services (Lachs & Pillemer, 2004). Consequently, findings should be interpreted with caution.

While attempts have been made to identify the factors responsible for substandard care and instances of abuse and neglect in care home and large scale inpatient settings, no attempts have been made to rigorously review and synthesise existing available research evidence. Consequently, the aim of this paper is to conduct a systematic review of empirical research (quantitative as well as qualitative) that has aimed to identify causal factors associated with abuse and neglect in such settings in order to provide an overview of the evidence base so far. This, in turn, should raise key implications for clinical practice and adult protection policy, as well as identifying opportunities for future research.

1.3 Method

1.3.1 Review Protocol

Within existing healthcare settings, evidence based practice and policy are generally considered key to the provision of high quality services (Trinder & Reynolds, 2000). Therefore, to inform policy and best practice, methods of summarising existing evidence within a particular area of research have been developed. In relation to this, systematic reviews are now considered the foundation for the evidence-based practice and policy movement (Yuan & Hunt, 2009). Traditionally, systematic review protocols encourage the implementation of rigorous quantitative designs (Higgins & Green, 2006). However, it has been suggested that more rigorous systematic review procedures, such as meta-analysis, may have limitations when the aim of a review is to construct a critical overview of a specific body of literature (Dixon-Woods et al., 2006). For example, when randomised controlled trials or controlled observational studies are not the most prominent sources of available literature, adopting a rigorous quantitative design may limit the ability to comprehensively review and

synthesise available evidence. In such situations, more descriptive, qualitative methods are encouraged (Harden & Thomas, 2005; Yuan & Hunt, 2009). Consequently, to account for the likely variation in study designs, a more descriptive systematic approach was utilised to encourage the extraction of rich, detailed information from the available research evidence.

1.3.2 Sources

The following methods were used to identify relevant published studies. First, electronic searches of the following databases were carried out: MEDLINE, PsycINFO, PubMed, PsycARTICLES and the Cochrane Library. Potentially relevant citations in articles identified by the electronic searches were also examined and where existing relevant review articles were identified, these were hand searched. Finally, hand searches of the following journals were conducted: *Journal of Elder Abuse*; *Journal of Adult Protection*.

The following keyword combinations were used for electronic database searches: [ABUS*] OR [NEGLECT*] OR [MISTREAT*] AND [“RESIDENTIAL CARE”] OR [RESIDENTIAL SERVICE*] OR [INPATIENT*] OR [HOSPITAL*]. The study selection process and the filtering process are summarised in Figure 1.1. For inclusion, studies were required to meet the following criteria:

1. English language articles
2. Articles published in a peer review journal
3. Articles reporting on empirical research aimed at identifying or exploring causal and/or risk factors associated with abuse and/or neglect in residential care services.

For the purposes of this review, abuse was defined as a violation of an individual's human and civil rights by any other person or persons (DH, 2000). It may be physical, verbal or psychological in nature; it may consist of a single act or repeated acts; and it may also be an act of neglect or an omission to act.

4. Articles focusing on residential care of adults (aged 18+) or older adults (aged 65+) within physical health, mental health or learning disability services.
5. Literature available up to September 2013

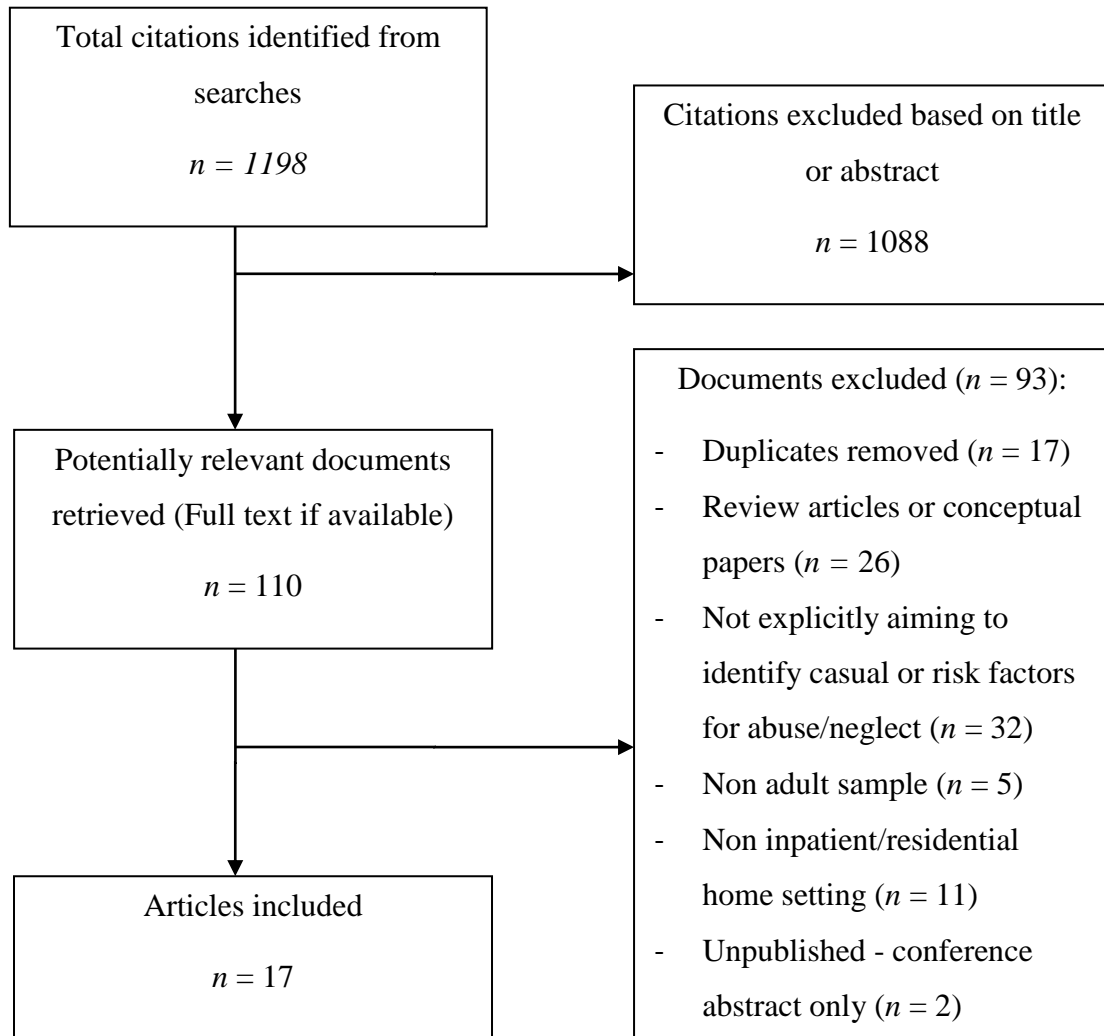


Figure 1.1 Study Selection Process

1.3.3 Procedure

Potentially relevant articles were identified using the search strategies described above. These were subsequently reviewed and hard copies of all publications that met the inclusion criteria were obtained. Descriptive summary characteristics were then collated for each study (see Table 1.2).

1.3.4 Study Quality Assessment

Within the clinical psychology and wider health and social care literature a considerable body of research exists, which seeks to identify quality criteria for the evaluation of empirical research (e.g. Chambless & Hollon, 1998; Downs & Black, 1998; Verhagen et al., 1998). However, these typically focus on research aimed at answering questions of effectiveness (i.e. studies that attempt to evaluate/explore the efficacy of specific therapies or treatment methods) and emphasise the value of carefully controlled, randomised designs involving multiple comparison groups or conditions. Due to the retrospective nature of research aimed at understanding the causes or risk factors associated with abuse in residential care facilities, such methodologies are rarely implemented in this area of research. Instead, research in this area is representative of a range of approaches, both quantitative and qualitative in nature. Consequently, in order to synthesise and critically appraise the diverse range of methods utilised, more general research quality markers were considered. Therefore, the mixed methods criteria outlined by Sale and Brazil (2004) were adopted, which advocate a cross-paradigm framework of trustworthiness and rigour. This framework was originally proposed by Lincoln and Guba (1986) and encompasses four goals, which are applicable across different methodologies and paradigms. For a summary of the framework, its associated goals and examples of how these might be achieved see Table 1.1. Using Sale and Brazil's (2004) framework, design characteristics and quality indicators were identified and detailed in Tables 1.3 and 1.4.

Table 1.1 Summary of cross-paradigm framework of trustworthiness and rigour (adapted from Sale & Brazil, 2004 & Lincoln & Guba, 1986)

| Goal | Description | Example Quality Markers (Qualitative) | Example Quality Markers (Quantitative) |
|------------------|---|---|---|
| 1. Truth Value | Refers to having a high level of confidence in the 'truth' of the findings (i.e. is there evidence for internal validity or credibility?). | <ul style="list-style-type: none"> • Triangulation of sources & methods • Member checking • Use of supporting raw data quotes • Negative case analysis or searches for disconfirming evidence | <ul style="list-style-type: none"> • Identification & control of extraneous variables • Statement about comparability of control group and intervention group |
| 2. Applicability | Refers to the findings being applicable to other contexts (i.e. is there evidence for external validity/generalizability or transferability/ fittingness?). | <ul style="list-style-type: none"> • Clear statement of research purpose and research question • Design explicitly stated • Clear description and justification for study context or setting • Clear description and justification for sampling strategy & participants • Transparent account of data analysis process | <ul style="list-style-type: none"> • Objective clearly stated • Design explicitly stated • Clear description of setting or conditions • Clear description of sampling, recruitment, inclusion/exclusion criteria & participants • Clear description of data collection instruments and procedures • Power calculation • Acknowledgement of statistical and clinical significance |
| 3. Consistency | Refers to being able to demonstrate that the findings are consistent and could be repeated (i.e. is there evidence for reliability or dependability?). | <ul style="list-style-type: none"> • External audit of process | <ul style="list-style-type: none"> • Standardization of tools or observers |
| 4. Neutrality | Refers to a high degree of neutrality or confidence in the extent to which the findings of a study are shaped by respondents and not sources of bias (i.e. is there evidence for objectivity or confirmability?). | <ul style="list-style-type: none"> • Statement of researchers' assumptions and perspective • Use of bracketing | |

1.4 Results

Electronic searches identified 17 papers, reporting on 15 separate studies, which met the inclusion criteria for this review. General study characteristics and findings are summarised in Table 1.2 and relevant design characteristics/methodological quality indicators are summarised in Tables 1.3 and 1.4.

1.4.1 General Sample Characteristics

The 15 studies identified were published between 1986 and 2013, with 9 being published since 2001. Studies were published in range of peer reviewed health and social care related journals. In addition, 8 of the 17 papers included were reported in publications dedicated to the dissemination of research into abuse, neglect and adult protection issues. Of the 15 studies reviewed, 11 were reporting on research conducted in either the United States ($n = 7$) or United Kingdom ($n = 4$). The remaining studies were conducted in Germany ($n = 2$), the Czech Republic ($n = 1$) and Thailand ($n = 1$).

1.4.2 Contextual Characteristics

Of the 15 reviewed studies, which aimed to explore the phenomenon of abuse and/or neglect in residential services, 11 described research focussing on the residential care of older adults and 4 described research focussing on the residential care of adults with learning disabilities. Therefore, no studies reporting on research within mental health or physical disability services were identified by this review. Multiple types of abuse were accounted for by the reviewed articles and 12 of the 15 studies referred to more than one category of abuse. Of the 15 studies, 11 made reference to physical abuse, 10 to neglect, 7 to emotional/psychological abuse, 4 to financial abuse, 3 to sexual abuse, 1 to substandard care and 1 to exploitation.

Table 1.2 Study Characteristics (papers presented in alphabetical order)

| Study | Journal | Country of Origin | Service Context | Abuse/Neglect Context | Design | Participants/data source(s) | Summary of Findings |
|--------------------------|-------------------------------|-------------------|--|---|---|---|---|
| Burns et al. (2013) | Sociology of Health & Illness | United Kingdom | Older adult nursing homes | “Institutional” – incorporating neglect, mistreatment & substandard care. | Qualitative: Comparative case study based, incorporating thematic analysis. | <ul style="list-style-type: none"> - Observations carried out in 8 care homes - Interview data from 86 members of staff & 38 residents - Policy documents. | Causes of institutional abuse were deemed to be link to specific care practices. Specifically, <i>linear problem-solving</i> or an <i>inability of staff to adapt to changing care needs over time</i> (termed “tame solutions”) were seen to both perpetuate & lead to mistreatment or substandard care. (CO ¹) |
| Buzgova & Inanova (2009) | Nursing Ethics | Czech Republic | Older adult nursing homes | Physical, psychological/ emotional, financial & neglect. | Qualitative: Phenomenological. | <ul style="list-style-type: none"> - Interview data from 20 care home residents & 28 care home employees (including two managers) - Formal complaint documents | Causes of elder abuse were representative of the following categories & sub-categories: <i>Institutional Characteristics</i> (organisation of work, staffing, regimens); <i>Employee Characteristics</i> (Burnout, personal problems, education); & <i>Residents' Characteristics</i> (individual characteristics, isolation). – (CO; S; SU) |
| Cambridge (1999) | Disability & Society | United Kingdom | Residential care for adults with learning disabilities | Physical, neglect & financial. | Qualitative: Case study based qualitative enquiry, incorporating thematic analysis. | <ul style="list-style-type: none"> - Post-incident reports - Care records - Service policy documents - Interviews data from stakeholders (e.g. managers, MDT members, service users & relatives). | <i>Service culture</i> was identified as the overarching cause of the cases examined. The following characteristics were reportedly associated with a culture of abuse: <i>Service Isolation; Ineffective Staff Supervision; Inexperience; Intimidation; Multiple Barriers to Disclosure; Poor Communication; Lack of Clarity in Care Management</i> – (CO; S) |

¹ CO - Cultural or Organisational Characteristics; S - Staff Characteristics; SU - Service-User Characteristics

| Study | Journal | Country of Origin | Service Context | Abuse/Neglect Context | Design | Participants/data source(s) | Summary of Findings |
|--------------------|----------------------------------|-------------------|---------------------------|--|--|--|---|
| Conlie-shaw (1998) | Journal of Elder Abuse & Neglect | United States | Older adult nursing homes | Physical & neglect - in response to service user aggression. | Qualitative: Grounded Theory | <ul style="list-style-type: none"> - Interview data from 6 abuse investigators & 15 nursing home staff members (9 nurses, 3 nursing assistants & 3 administrators) - Incident report logs | Results describe a “basic social psychological process” whereby people develop <i>immunity to aggression</i> . Therefore, an inability to develop or a <i>loss of immunity</i> , are proposed as a risk factor for abuse & neglect. Factors that facilitate the process of developing immunity are also identified. (S) |
| Goergen (2001) | Journal of Elder Abuse & Neglect | Germany | Older adult nursing homes | Physical, neglect & psychological/emotional. | Cross-sectional survey | <ul style="list-style-type: none"> - Questionnaire survey data from 79 carers (38 nurses, 25 nursing aides & 16 care assistants). | The main factors to which subjects attribute abuse & neglect in nursing homes were: <i>staff shortages & caregiver-overload</i> . Alongside this, a number of specific <i>caregiver characteristics</i> were also highlighted as possible risk factors (e.g. <i>lack of empathy, nervous disposition, pre-existing personal problems</i>). (CO; S) |
| Goergen (2004) | Journal of Adult Protection | Germany | Older adult nursing homes | Physical, psychological/emotional & neglect. | Multi-method study: Incorporating qualitative interviews, cross-sectional survey & case study review | <ul style="list-style-type: none"> - Interview data from 251 stakeholders (i.e. staff, residents, family members). - Questionnaire survey data from 361 staff members. - Analysis of public prosecutor’s files - 35 cases. - 188 on-site inspection reports. | The following were found to be correlated with self-reported incidents of abuse and neglect: <i>high percentage of un-qualified staff; low job satisfaction; dissatisfaction with management; physical aggression from residents; emotional exhaustion; & stress induced alcohol consumption</i> by staff. (CO; S; SU) |

| Study | Journal | Country of Origin | Service Context | Abuse/Neglect Context | Design | Participants/data source(s) | Summary of Findings |
|---|---|-------------------|--|---|--|--|---|
| Jogerst et al. (2006) | Journal of the American Medical Directors Association | United States | Older adult nursing homes | Physical, sexual, neglect & exploitation. | Cross-sectional survey | <ul style="list-style-type: none"> - Questionnaire survey data from 598 nursing home administrators & directors - Independent nursing home reports - Local census demographics | <i>Higher numbers of residents & certified beds</i> were significantly associated with higher incident report & substantiation rates. Higher incident & report rates were associated with <i>nursing homes in metropolitan areas</i> . Higher substantiation rates were associated with <i>for-profit nursing homes</i> . (CO) |
| Marsland et al. (2007) | Journal of Adult Protection | United Kingdom | Residential care for adults with learning disabilities | Physical, sexual, psychological/emotional, financial, material & neglect. | Qualitative: Thematic content analysis | <ul style="list-style-type: none"> - Interview data from 18 professionals & 3 family members associated with services where abuse occurred. - 2 files detailing professionals' concerns about services where abuse occurred. | Six themes representing observed indicators of abuse were identified: <i>Decisions, attitudes & actions of managers; Behaviours & attitudes of staff; Behaviours of residents; Isolation; Service Design; & Fundamental care & the quality of the environment</i> . (S; SU; CO) |
| Payne & Cikovic (1995) | Journal of Elder Abuse & Neglect | United States | Older adult nursing homes | Physical, sexual, financial & neglect. | Qualitative: Thematic content analysis | - 488 incident reports of patient abuse | Thematic analysis revealed the following risk factors to be associated with abuse: <i>Service User Gender; Pressures of the job; Staff Training/Experience</i> . (SU, S) |
| Pillemer & Moore (1989; 1990) & Pillemer & Bracham-Prehn (1991) | The Gerontologist; Journal of Elder Abuse & Neglect; Research on Ageing | United States | Older adult nursing homes | Physical & psychological/emotional. | Random sample, cross sectional survey. | - Telephone interview data from 479 nurses & nursing aides (from 32 nursing homes). | Predictors of inappropriate physical & psychological actions were experiences of: <i>staff-patient conflict, patient aggression & burnout</i> . Additional predictors of inappropriate psychological actions were <i>negative staff attitudes & young staff</i> . (SU; S) |

| Study | Journal | Country of Origin | Service Context | Abuse/Neglect Context | Design | Participants/data source(s) | Summary of Findings |
|--------------------------|--|-------------------|--|------------------------------------|---|--|---|
| Rusch et al. (1986) | American Journal of Medical Deficiency | United States | Residential care for adults with learning disabilities | Physical | Semi-randomised, case controlled study. | - Medical & care records of 160 service users (80 victims of abuse; 80 controls). | Six <i>client characteristics</i> (social quotient, aggression, verbal ability, age, self-injurious behaviour & ambulation) were significant in differentiating between abused & non-abused residents. (SU) |
| Schiamberg et al. (2012) | Journal of Elder Abuse & Neglect | United Kingdom | Older adult nursing homes | Physical | Random sample, cross sectional survey | - Telephone survey data from 452 adult relatives of people in nursing home care | <i>Limitations in activities of daily living, behavioural difficulties, & previous victimization by non-staff perpetrators</i> were associated with a greater likelihood of physical abuse. (SU) |
| Wang (2005) | Journal of Nursing Research | Taiwan | Older adult nursing homes | Psychological/emotional | Cross-sectional survey | - Questionnaire data from 114 randomly selected members of care staff. | Psychological abuse behaviour was significantly associated with caregiver: <i>age, professional status, educational level/training & burden</i> . Therefore, those: younger in age, less educated, lacking in geriatric training & who felt a greater burden, displayed a tendency toward more abusive behaviour. (S) |
| Zhang et al. (2011) | Journal of Elder Abuse & Neglect | United States | Older adult nursing homes | Physical neglect | Random sample, cross-sectional survey | - Telephone survey data from 414 adult relatives of people in nursing home care | Two residents' characteristics appeared to significantly increase the odds of neglect: <i>Functional impairments in activities of daily living & previous resident-to-resident victimization</i> . (SU) |
| Zirpoli et al. (1987) | Journal of Special Education | United States | Residential care for adults with learning disabilities | Physical & psychological/emotional | Semi-randomised, case controlled study. | - Primary care-giver ratings of 182 services users (91 - confirmed abuse cases; 91 - randomly selected controls) | <i>Level of functioning & frequency of maladaptive behaviours</i> were significantly related to abuse status. As were, a linear combination of characteristics (<i>level of functioning, auditory ability, ambulatory ability & frequency of violent/hyperactive behaviour</i>). (SU) |

1.4.3 Study Design Characteristics

A range of research designs were described by the included studies. Specifically, 8 of the reviewed studies adopted quantitative approaches, 6 described qualitative designs and 1 study (Goergen, 2004) adopted what was referred to as a multi-method approach. Of the 8 studies adopting quantitative designs, 6 were cross sectional surveys and 2 were semi-randomised case controlled designs. Of the 6 qualitative designs, 4 described the thematic analysis of one or more qualitative data sources (i.e. semi-structured interviews, observations, clinical or policy related documentation) and the remaining 2 referred to specific methodologies (i.e. Grounded Theory) or an approach informed by a particular theoretical perspective (i.e. Phenomenology). The remaining multi-method study incorporated a thematic analysis of qualitative interviews and case study material, alongside a cross-sectional survey. A summary of specific study quality markers is provided in section 1.4.5.

A wide range of data sources and/or participants were represented by the reviewed studies. Specifically, 9 of the reviewed studies incorporated data obtained through structured or semi-structured interviews with either staff members ($n = 7$), service users ($n = 4$), relatives of service users ($n = 5$) or incident investigators ($n = 1$). Additionally, 5 studies incorporated data obtained from structured questionnaires ($n = 4$) or self-report rating scales ($n = 1$), administered to staff members ($n = 4$) or primary care givers/relatives ($n = 1$). Also 8 studies incorporated data from a range of written sources, including: policy documents ($n = 2$), independent inspection reports ($n = 2$), incident reports ($n = 3$), care records ($n = 2$) health professional's files ($n = 1$) and written complaints ($n = 1$). Finally, 8 of the reviewed studies utilised multiple data sources and/or methods.

1.4.4 Findings: Causal and/or Risk Factors Identified

Due to the range of different methodologies adopted by the reviewed studies, findings were based on a number of different sources of evidence and analytic procedures. Of the six cross

sectional survey designs within the quantitative data set, four identified staff, service user or nursing home characteristics that were correlated with higher rates of abuse and/or neglect. Of the two studies that explored service user characteristics, one focussed explicitly on physical abuse (Schiamberg et al., 2012) and the other on neglect (Zhang et al., 2011). Both identified *functional impairments in activities of daily living* and *previous resident-to-resident victimization* to be correlated with higher incident rates (of either abuse & neglect). In addition, Schiamberg et al. (2012) revealed *behavioural difficulties*, to be a further correlate of physical abuse. The study that explored staff characteristics (Wang, 2005), focussed explicitly on psychological/emotional abuse and revealed that abuse behaviour was significantly associated with caregiver: *age, professional status, educational level/training* and *burden*. Specifically, those: younger in age, less well educated, lacking in specific training and who perceived a greater burden, displayed a tendency toward more abusive behaviour. The study that explored nursing home characteristics (Jogerst et al., 2006) focussed on neglect, exploitation and physical and sexual abuse. It was revealed that *higher numbers of residents and certified beds* were significantly associated with high incident report and substantiation rates. High incident and report rates were also associated with *nursing homes in metropolitan areas*, and high substantiation rates were associated with *for-profit nursing homes*. Of the remaining two studies that adopted cross sectional survey designs, one reported frequency data relating to staff members' subjective explanations for causes of abuse or neglect (Goergen, 2001) and the other reported differences between the characteristics of staff that had committed either physical or psychological abuse with those that had not (Pillemer & Moore, 1989; 1990; Pillemer & Bracham-Prehn, 1991). Goergen (2001) revealed that staff attributed abuse or neglect to: *staff shortages, caregiver-overload, staff lacking in empathy, staff of a nervous disposition* and *staff with pre-existing personal problems*. Pillemer and Moore (1989; 1990) and Pillemer and Bracham-Prehn (1991) revealed that the following

characteristics differentiated between staff that had committed inappropriate physical and psychological actions: *experiences of staff-patient conflict, experiences of patient aggression and burnout*. In addition, inappropriate psychological actions were also found to be associated with: *negative staff attitudes and young staff members*.

Of the remaining two studies in the quantitative data set, which adopted semi-randomised case controlled designs (Rusch et al., 1986; Zirpoli et al., 1987), both compared the characteristics of service users' who had been subjected to abuse to those who had not. Rusch et al. (1986) focused on physical abuse and identified six client characteristics (*social quotient, aggression, verbal ability, age, self-injurious behaviour & ambulation*) that were significant in differentiating between abused and non-abused residents. Zirpoli et al. (1987) focussed on abuse that was either physical or psychological in nature and identified that *level of functioning and frequency of maladaptive behaviours* were significant in differentiating between abused and non-abused residents.

Within the quantitative data set, four of the studies' results represented prominent themes derived from thematic analyses of a range of qualitative data sources. Burns et al. (2013) identified the following causes of institutional abuse (derived from interview, observational & care record based data) which they linked to specific care practices: *linear problem-solving and an inability of staff to adapt to changing care needs over time*. Cambridge (1999) identified the following themes (derived from interview data & service documentation), which were felt to be characteristics of a culture of abuse (incorporating physical abuse, neglect or financial abuse): *service isolation, ineffective staff supervision, inexperience, intimidation, multiple barriers to disclosure, poor communication, and lack of clarity in care management*. Marsland et al. (2007) identified the following themes (derived from interview data & service documentation), which were considered observed indicators of abuse (of either a physical, sexual, psychological, financial or material nature): *decisions, attitudes & actions*

of managers; behaviours & attitudes of staff; behaviours of residents; isolation; service design; and fundamental care & the quality of the environment. Payne and Cikovic (1995) identified the following themes (derived from incident reports), which were felt to be risk factors associated with either physical, sexual or financial abuse and neglect: *service user gender, pressures of the job, and staff training/experience.*

Of the remaining two studies in the qualitative data set, one presented themes based on a phenomenological study of service user and staff experiences (Buzgova & Inanova, 2009) and the other presented partial findings from a grounded theory investigation of the dynamics of abuse in nursing homes (Conlie-Shaw, 1998). Buzgova and Inanova (2009) identified the following themes and sub-themes (derived from interview data), which it was felt were related to the causes of elder abuse (incorporating physical, psychological/emotional, financial & neglect): *Institutional Characteristics (organisation of work, staffing, regimens); Employee Characteristics (burnout, personal problems, education); and Residents' Characteristics (individual characteristics, isolation).* Conlie-Shaw's (1998) results (derived from interview data & incident report logs) described a "*basic social psychological process*" whereby people were able to develop *immunity to aggression*. Therefore, an inability to develop or a loss of immunity, were proposed as risk factors for physical abuse and neglect.

Finally, the remaining multi-method study (Goergen, 2004) presented the results of a thematic analysis of interview data and case study material, alongside factors that correlated with self-reported incidents of either abuse or neglect. Results revealed that the following themes and/or factors were found to be associated with self-reported incidents of abuse and neglect: *high percentage of un-qualified staff, low job satisfaction, dissatisfaction with management, physical aggression from residents, emotional exhaustion, and stress induced alcohol consumption by staff.*

In summary, the causal and risk factors identified by the reviewed studies were representative of the following descriptive categories: Factors relating to *Cultural or Organisational Characteristics (CO)*; *Staff Characteristics (S)*; and *Service-User Characteristics (SU)*. Of the 15 studies reviewed, 7 identified causal or risk factors categorised as being related to cultural or organisational characteristics (CO), 9 identified causal or risk factors which were related to specific staff characteristics (S) and 9 reported causal or risk factors, which were related to specific service user characteristics (SU). Additionally, of all the studies where multiple categories of abuse were considered (e.g. physical, emotional, financial, neglect), only one attempt was made to differentiate between causes and/or risk factors associated with those individual categories (Schiamberg et al., 2012).

1.4.5 Study Quality Assessment

Tables 1.3 and 1.4 present an overview of the quality of the reviewed studies based on Sale and Brazil's (2004) cross paradigm framework. Table 1.3 identifies which of the quantitative studies included have demonstrated relevant quality indicators and Table 1.4 provides a summary of relevant quality indicators demonstrated by the qualitative studies. Where studies did make reference to a particular quality indicator, but did not provide sufficient detail to allow for the reviewer to ascertain whether the specific criteria had been met, this is also indicated. As one of the included studies adopted a multi-method design, which incorporated separate quantitative and qualitative elements (Goergen, 2004), this was evaluated according to both sets of criteria.

Of the 9 studies that adopted quantitative approaches, 2 described designs that incorporated a control or comparison condition, in order to enhance internal validity (Rusch et al., 1986; Zirpoli et al., 1987). In addition, while 6 of the quantitative studies made reference to extraneous or confounding variables, only 2 of those did this explicitly or provided sufficient detail (Goergen, 2001; Pillemer et al., 1989, 1990, 1991). Only 3 of the quantitative studies

made explicit reference to informed consent procedures (Schiamberg et al., 2012; Wang, 2005; Zhang et al., 2011), and only 1 explicitly stated that ethical review was undertaken (Jogerst et al., 2006). Other potential limitations identified within the quantitative data set were that only 5 studies described any form of randomization (Pillemer et al., 1989, 1990, 1991; Rusch et al., 1986; Schiamberg et al., 2012; Zhang et al., 2011; Zirpoli et al., 1987), and none made reference to statistical power calculations. Although the majority of quantitative studies did incorporate standardized outcome measures, only 3 made reference to the standardization of observers/raters, in order to demonstrate inter-rater reliability (Schiamberg et al., 2012; Zhang et al., 2011; Zirpoli et al., 1987). In summary, the quality assessment data revealed that many of the reviewed studies failed to report key characteristics or study quality indicators.

However despite the limitations described, the internal validity of the quantitative studies was enhanced by the fact that all provided evidence of a systematic analysis of data. The absence of statements regarding the comparability of intervention and control groups is also a reflection of the limited number of studies that incorporated a comparison condition, rather than an omission to report by the authors. External validity of the quantitative studies was enhanced by the fact that most presented a clear description of the study design, research process and sample/data source. In addition, all studies made reference to whether or not results were statistically significant and indicated the level of significance applied.

Table 1.3 Quality Indicators for Quantitative Studies (adapted from Sale & Brazil, 2004)

| Study: | | Goergen (2001) | Goergen (2004) | Jogerst et al., (2006) | Pillemer & Moore (1989; 1990) & Pillemer & Bracham-Prehn (1991) | Rusch et al. (1986) | Schiamberg et al. (2012) | Wang (2005) | Zhang et al. (2011) | Zirpoli et al. (1987) | Yes (Y) Totals (Max. = 9) |
|--|--|-------------------|-------------------|------------------------------|---|------------------------|-----------------------------|----------------|---------------------------|-----------------------------|---------------------------------|
| Truth Value Internal Validity | Extraneous/confounding variables identified | P | | Y | Y | | P | P | P | | 2 |
| | Control group | | | | | Y | | | | Y | 2 |
| | Statement about comparability of intervention & control groups at baseline | | | | | P | | | | Y | 1 |
| | Systematic analysis of data (P values and confidence intervals stated) | P | P | Y | Y | Y | Y | Y | Y | Y | 7 |
| | Informed consent stated | | | | | | Y | Y | Y | | 3 |
| | Ethical review undertaken | | | Y | | | | | | | 1 |
| Applicability External Validity/ Generalis- ability | Clearly stated objectives | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9 |
| | Design stated explicitly | P | Y | Y | | Y | Y | Y | Y | Y | 7 |
| | Clear rationale provided | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9 |
| | Clear description of research process & measurement tools (Replicable) | P | P | Y | Y | Y | P | Y | P | Y | 5 |
| | Demographic qualities of sample provided | Y | P | P | Y | Y | Y | Y | Y | Y | 7 |
| | Randomisation | | | | Y | P | Y | | Y | P | 3 |
| | Inclusion / exclusion criteria | P | | | Y | P | P | Y | P | P | 2 |
| | Power calculations | | | | | | | | | | 0 |
| | Statistical significance acknowledged | Y | Y | Y | Y | Y | Y | Y | Y | Y | 9 |
| Consistency Reliability | Standardisation of observers or inter-rater reliability | | | | | | P | | P | Y | 1 |
| | Standardised outcome measures | Y | P | P | Y | Y | | Y | | Y | 5 |
| Yes (Y) Totals (Max. = 17): | | 5 | 4 | 8 | 10 | 9 | 8 | 10 | 8 | 11 | |

Key:

- **Y** = Yes - clear evidence is presented
- **P** = Partly Yes - evidence is presented but not in sufficient detail
- **Left Blank** = No evidence presented

Within the qualitative data set, notable limitations concerned the fact that very few of the 7 studies incorporated member checking procedures (Conlie-shaw, 1998; Marsland et al., 2007) or a negative case analysis (Conlie-shaw, 1998), in order to enhance study credibility. In addition, only 2 qualitative studies explicitly stated that informed consent was obtained (Buzgova & Inanova, 2009; Marsland et al., 2007) and 3 stated that an ethical review had been undertaken (Burns et al., 2013; Buzgova & Inanova, 2009; Marsland et al., 2007). No qualitative studies clearly stated a coherent epistemological position, and only 3 made any reference to the theoretical perspective that had informed their work (Burns et al., 2013; Buzgova & Inanova, 2009; Conlie-Shaw, 1998). Also, none of the qualitative studies acknowledged the potential contribution of the researchers' own perspective through reflexivity or utilised techniques such as bracketing or an external audit of the process, in order to promote neutrality and consistency.

However despite these limitations, the credibility of the qualitative findings presented is enhanced by the fact that all studies attempted to ground their assertions in raw data, and provided clear evidence of this. In addition, 6 of the 7 qualitative studies utilised multiple sources, methods or observers (Triangulation). Finally, the potential transferability of the reviewed qualitative studies was enhanced by attempts to present a detailed and transparent account of the processes and procedures. However, while key design features were never omitted, in some instances transparency could have been enhanced by greater detail (see Table 1.4).

Table 1.4 Quality Indicators for Qualitative Studies (adapted from Sale & Brazil, 2004)

| Study: | | Burns et al. (2013) | Buzgova & Inanova (2009) | Cambridge (1999) | Conlie-shaw (1998) | Goergen (2004) | Marsland et al. (2007) | Payne & Cikovic (1995) | Yes (Y) Totals (Max. = 7) |
|--|---|---------------------|--------------------------|------------------|--------------------|----------------|------------------------|------------------------|---------------------------|
| Truth Value (Credibility) | Systematic analysis of data | Y | Y | P | Y | P | Y | P | 4 |
| | Triangulation | Y | Y | Y | Y | Y | Y | | 6 |
| | Member checks | | | | Y | | Y | | 2 |
| | Assertions grounded in raw data (quotations) | Y | Y | Y | Y | P | P | P | 4 |
| | Negative case analysis | | | | Y | | | | 1 |
| | Informed consent stated | | Y | | | | Y | | 2 |
| | Ethical review undertaken | Y | Y | | | | Y | | 3 |
| Applicability (Transferability/ fittingness) | Clearly stated objectives | Y | Y | Y | Y | Y | Y | Y | 7 |
| | Clear rationale provided | Y | Y | Y | Y | Y | Y | Y | 7 |
| | Clearly stated and coherent epistemological position | | P | | P | | | | 0 |
| | Relevant theoretical perspective stated | P | Y | | Y | | | | 2 |
| | Transparent description of sampling strategy/procedures | P | Y | Y | P | P | Y | Y | 4 |
| | Justification or rationale for sampling strategy | Y | P | P | P | P | Y | Y | 3 |
| | Demographic qualities of sample described | P | Y | P | Y | Y | P | Y | 4 |
| | Transparent account of data analysis process/procedures | P | Y | P | Y | P | P | P | 2 |
| | Use of reflexivity | | | | | | | | 0 |
| Consistency (Dependability) | External audit of process | | | | | | | | 0 |
| Neutrality (Confirmability) | Statement of researchers assumptions | | | | | | | | 0 |
| | Use of bracketing | | | | | | | | 0 |
| Yes (Y) Totals (Max. = 19): | | 7 | 11 | 5 | 10 | 4 | 9 | 5 | |
| Key: | | | | | | | | | |
| <ul style="list-style-type: none"> Y = Yes - clear evidence is presented P = Partly Yes - evidence is presented but not in sufficient detail Left Blank = No evidence presented | | | | | | | | | |

1.5 Discussion

The aim of this systematic review was to provide a synthesis of existing research evidence on causal and risk factors associated with the abuse and neglect of adults in residential care. Fifteen relevant studies were included, which explored abuse and/or neglect within residential services for older adults and adults with learning disabilities. Results revealed that attempts to understand possible causal factors associated with abuse and neglect are representative of a range of research approaches and designs. While there are limitations associated with presenting a synthesis of such a diverse group of studies, this paper highlights the complex range of factors that appear to be linked to the abuse and neglect of adults in residential care. In addition, readers are able to obtain a comprehensive overview of the quality of empirical research within this area.

Although substandard care practices and/or abuse have been documented across a range of inpatient and residential health and social care settings (Manthorpe & Martineau, 2011; Ramsey-Klawnsnik et al., 2007; Reese & Manthorpe, 2010), this review has revealed that research into causal or risk factors is dominated by studies focussing on care facilities for older adults. While some attempts have been made to explore the phenomenon of substandard care in services for adults with learning disabilities, no empirical research has focused on other inpatient or residential settings (i.e. services for adults with physical & mental health difficulties). Currently, a high proportion of UK residential care facilities for adults are elderly care homes, which has been attributed to an increasingly ageing population and a shift towards supporting working age adults with physical health problems, mental health difficulties and learning disabilities in the community (CQC, 2012a). Therefore, the lack of research relevant to physical and mental health residential settings reflects this shift in care culture and associated health and social care provisions.

1.5.1 Theoretical Implications

The aim of this study was to synthesise existing evidence on causal and risk factors associated with the abuse and neglect in residential care, and Table 1.2 presents the factors identified by each of the fifteen studies. Three categories of causal and risk factors were defined. The first category identified those at a cultural or organisational/environmental level (CO) and includes factors relating to the *service culture*, *institutional characteristics* and specific *care practices*. The second and third categories include factors at an individual level and describe specific *staff* (S) and *service-user* (SU) *characteristics*, which appear to be correlated with abusive and neglectful practices. Therefore, the results of this review appear to offer support for previously described conceptual frameworks and narrative review evidence. Specifically, Sobsey (1994) suggested that causal factors could be understood as fitting under the following three main headings or levels: the *wider culture*, the *specific care environment*, and the *relationship between carer and the person being cared for*. Early empirical support for this model has also been documented in a selective narrative review by Moore (2001).

While the first two of Sobsey's (1994) levels are accounted for by the first category of results described in this review, less empirical support appears to exist for the interpersonal level identified by Sobsey (1994). However, closer inspection of some of the findings relating to staff (S) or service-user (SU) characteristics highlights a number of factors, which may be best understood from the perspective of an interaction or interpersonal relationship between the staff member (or carer) and the service user. Specifically, service user related risk factors such as exhibiting frequent maladaptive or challenging behaviour, were highlighted by a number of the reviewed studies (e.g. Goergen, 2004; Pillemer et al., 1989, 1990, 1991; & Zirpoli et al., 1987). Alongside this, staff characteristics, such as burnout (e.g. Buzgova & Inanova, 2009), emotional exhaustion (e.g. Goergen, 2004) and level (or lack) of experience (e.g. Payne & Cikovic, 1995; Wang, 2005) were also identified as causal and/or risk factors.

Although these are often identified as discrete risk factors within the literature, wider research evidence highlights a considerable interaction between and within these two categories (i.e. Staff & Service User characteristics). For example, a study conducted by Whittington (2002) into nurse attitudes towards patient aggression, within an inpatient mental health setting, revealed that tolerance for aggression was higher for more experienced staff and this, in turn, was associated with low levels of emotional exhaustion and subsequent burnout rates. In addition, there is a considerable body of literature exploring the dynamics of staff burnout within services for people with learning disabilities, which has highlighted potential causal links with more dynamic or relational factors, such as negative emotional reactions to aggressive or challenging resident behaviour (e.g. Mills & Rose, 2011; Mitchell & Hastings, 2001; Rose, Horne, Rose & Hastings, 2004).

The findings of this systematic review indicate that a considerable amount of existing research evidence aimed at understanding abuse in residential care consists of relatively superficial (i.e. descriptive) information. This is consistent with concerns that have previously been voiced about the quality of older adult research (Daly, Merchant & Jogurst, 2011). Such concerns appear to highlight a need for different research approaches to be considered. For example, the interaction between service-user and staff characteristics, detailed in Conlie-Shaw's (1998) Grounded Theory study, where some staff were able to develop an immunity or resilience to aggression from service users, captures in detail the potentially complex and dynamic nature of abusive and neglectful practices. This demonstrates the potential of more exploratory (qualitative) research methodologies, which may need to be considered alongside more traditional objective (quantitative) research designs.

In addition to factors that operate at an individual or interpersonal level, this review also highlights wider cultural and environmental factors as potentially significant sources of influence on quality of care and absence/presence of abusive or neglectful practice in

residential services. This is consistent with existing review evidence (e.g. White, Holland, Marsland & Oaks, 2003) and recent empirical research aimed at exploring the factors associated with underperforming care homes (Bigby, Knox, Beadle-Brown, Clement & Mansell, 2012), where calls have been made for greater attention to be paid to the potential of environments and cultures to increase people's vulnerability to abuse and neglect. As a higher proportion of the reviewed studies highlighting such factors adopted more exploratory qualitative research designs (e.g. Burns et al., 2013; Buzgova & Inanova, 2009), the recent shift in attention to more cultural and organisational factors may reflect changes in research traditions and practices. Additionally, it is important to recognise that although a distinction has been made between cultural or organisational factors and interpersonal factors, there is likely to be considerable interplay between the two. For example, research evidence has found that the provision of regular supervision for care staff can reduce levels of stress and burnout in staff (Ito, Kurita & Shiiya, 1999), which in turn is likely to impact positively on care practices.

1.5.2 Applied Implications

Calls have been made for greater attention to be paid to cultural and organisational factors at an applied level (e.g. White et al., 2003). Specifically, it has been argued that much of the available policy and guidance is reflective of a reactive stance, which has a tendency to attribute abusive practices to individual deviancy and culpability (White et al., 2003). Arguably, the potential consequences of such a stance, is the implementation of responses to abuse or preventative measures that fail to address the actual underlying causes. Therefore, the results of this review provide additional support for the need for preventative measures that operate at a cultural/organisational level (e.g. policies and practices related to staff training, supervision, whistle blowing, general care principles, staff wellbeing etc.). This may necessitate a shift away from a culture of focusing on specific care practices to a more holistic

approach, which takes into account a wide range of interacting factors that may influence care standards. A possible example of this can be observed in the field of dementia care, where the principles of *Person Centred Care* (originally described by Kitwood, 1993) are becoming increasingly embedded within the culture of services (Brooker, 2004).

1.5.3 Limitations and Future Research Directions

A potential limitation of this review is that many of the reviewed studies failed to describe potentially important design characteristics or study quality indicators. While it is common practice when conducting systematic reviews to exclude research that fails to meet a pre-determined methodological standard or set of design characteristics (Downs & Black, 1998), due to the potentially limited amount of research in this area, the criteria for inclusion in this review was relatively relaxed. Therefore, in some instances the level of methodological rigour applied was questionable. Consequently, definitive interpretations of the combined findings presented cannot be made. However, as no previous attempts have been made to rigorously review and synthesise available research evidence on the causes and/or risk factors associated with instances of abuse and neglect in care home and residential settings, this provides a valuable summary of the state of research in this area, and highlights a number of potentially fruitful future research directions.

The range of methodological approaches adopted and variation in study quality observed may also be a reflection of the difficulties associated with conducting research in this field. Specifically, research in this area is typically retrospective in nature (i.e. focussed on understanding past events), which limits the type of research designs that can be adopted. Specifically, this review has revealed that attempts to apply quantitative approaches are typically correlational in nature and seek to identify specific factors or characteristics, which may be associated with or related to previously confirmed or self-reported past incidents of abuse and neglect. Clearly such designs limit the extent to which it is possible to control for

sources of bias and potentially confounding variables, which in turn limits the validity of the findings. However, this review has also demonstrated that more rigorous quantitative designs, such as semi-randomised case controlled studies (e.g. Rusch et al., 1986 & Zirpoli et al., 1987) can be applied in this field. These designs allow for a systematic comparison of individuals, organisations or environments, where substandard care or abusive practices are observed with individuals, organisations or environments where this is not the case. An alternative to such an objective stance is to consider the potentially insightful nature of socially constructed or experiential sources of information. This typically necessitates the application of more 'qualitative' forms of enquiry. However, with the exception of two of the reviewed studies (Buzgova & Inanova, 2009 & Conlie-shaw, 1998), existing qualitative research tends to adopt a more descriptive approach (i.e. thematic analysis), which arguably provides limited theoretical or explanatory insight (Daly et al., 2007). Consequently, future research should consider adopting more in-depth phenomenological (e.g. Smith, 1996; Smith, Flowers & Larkin, 2009) or Grounded Theory (Charmaz, 2006; Glaser & Strauss 1967) based qualitative approaches, to gain additional theoretical or experiential insight into the phenomenon of abuse. The highly sensitive nature of this type of research also raises a number of potential ethical considerations, which may act as barriers to the advancement of scientific investigation. For example, it may be difficult to recruit and obtain consent from participants who could offer potentially valuable insight into substandard or abusive practices (e.g. abuse perpetrators or staff working in care environments where abuse has occurred), and where such participants are recruited, they may be reluctant to disclose specific information in fear of the potential consequences. In relation to this, it is crucial for future research to undergo appropriate ethical review, observe informed consent procedures and report on this.

As mentioned earlier, a large proportion of the studies included in the current review reported on research conducted in older adult settings. While this appears to be a reflection of the fact

that a high proportion of residential care facilities for adults are elderly care homes (CQC, 2012a), there remains a need for the phenomenon of abuse in residential care to be investigated across a range of settings. Therefore, future research should look to expand the existing research base in this area by conducting studies into abuse and neglect within other residential care settings. This will allow for comparisons to be made between different health and social care sectors, providing a potentially greater depth of insight into the potential causes of substandard care and abusive practices.

In addition, the phenomenon of abuse can be broken down into a number of more discrete forms (e.g. physical, neglect, emotional/psychological, sexual & financial). Despite this, the results of this review revealed that research in this area typically groups these more discrete forms together when investigating causal or risk factors. While this approach is likely to lead to the identification of a more comprehensive range of potential causes or risk factors, it also neglects the possibility that different forms of abuse may be associated with different underlying causes. For example, a research study exploring risk factors associated with community-based elder abuse revealed that the specific factors identified were sometimes only relevant to certain forms of abuse (Choi & Mayer, 2000). This suggests a need for future research in this area to differentiate between different types of abuse or neglect.

1.6 Conclusion

In summary, this review has provided a synthesis of existing research evidence on causal and risk factors associated with the abuse and neglect of adults in residential care. Although the issue of substandard care and abuse in residential adult services has been well documented for many years (e.g. Furey, 1989; Pillemer, 1988), research to date aimed at understanding this phenomenon appears to remain underdeveloped. However, the diverse range of articles summarised in this review has allowed for a synthesis of relevant research that draws on information obtained from a range of sources and methodological approaches. Ultimately, this

highlights the potentially complex range of factors associated with the abuse and neglect of adults in residential care and offers some limited empirical support for the existing theoretical literature. In addition, a number of applied implications and future research directions are highlighted, which may contribute to the development of further research and ultimately to improvements in residential care standards and a reduction in future instances of abuse and neglect.

1.7 References

- Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., & Whelton, B. (2010). Adult protection of people with intellectual disabilities: Incidence, nature and responses. *Journal of Applied Research in Intellectual Disabilities*, 23, 573-584.
- Bigby, C., Knox, M., Beadle-Brown, J., Clement, T., & Mansell, J. (2012). Uncovering dimensions of culture in underperforming group homes for people with severe intellectual disability. *Intellectual & Developmental Disabilities*, 50(6), 452-467.
- Brooker, D. (2004). What is person centred care in dementia? *Reviews in Clinical Gerontology*, 13, 215-222.
- Burns, D., Hyde, P., & Killet, A. (2013). Wicked problems or wicked people? Reconceptualising institutional abuse. *Sociology of Health and Illness*, 35(4), 514-528.
- Buzgova, R., & Inanova, K. (2009). Elder abuse and mistreatment in residential settings. *Nursing Ethics*, 16(1), 110-126.
- Cambridge, P. (1999). First hit: A case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability & Society*, 14(3), 285-305.
- Care Quality Commission (2012a). *The State of Health Care and Adult Social Care in England in 2011/12*. London: The Stationary Office.
- Care Quality Commission (2012b). *Learning Disability Services Inspection Programme: National Overview*. Newcastle: The Care Quality Commission
- Care Quality Commission (2012c). *Time to Listen: Dignity and Nutrition Inspection Programme*. Newcastle: The Care Quality Commission
- Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7.
- Charmaz, K. (2006). *Constructing Grounded Theory*. London: Sage.
- Choi, N. G., & Mayer, J. (2000). Elder abuse, neglect, and exploitation: Risk factors and prevention strategies. *Journal of Gerontological Social Work*, 33(2), 5-25.
- Conlie-shaw, M. M. (1998). Nursing home resident abuse by staff: Exploring the dynamics. *Journal of Elder Abuse & Neglect*, 9(4), 1-21.
- Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing*, 37, 151-160.
- Daly, J. M., Merchant, M. L., & Jogurst, G. J. (2011). Elder abuse research: A systematic review. *Journal of Elder Abuse and Neglect*, 23, 348-365.

- Daly, J., Willis, K., Small, R., Green, J., Welch, N., Kealey, M., & Hughes, E. (2007). A hierarchy of evidence for assessing qualitative health research. *Journal of Clinical Epidemiology*, 60, 43-49.
- Department of Health (2000). *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. London: Department of Health.
- Department of Health (2012). *Transforming Care: A National Response to Winterbourne View Hospital*. London: Department of Health.
- Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R. & Sutton A.J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology*, 6, 1-13.
- Downs, S. H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *Journal of Epidemiology & Community Health*, 52, 377-384.
- Flynn, M. (2012). *Winterbourne View Hospital: A Serious Case Review*. South Gloucestershire Council.
- Furey, E. M. (1989). Abuse of persons with mental retardation: A literature review. *Behavioral Residential Treatment*, 4(2), 143-154.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.
- Goergen, T. (2001). Stress, conflict, elder abuse and neglect in German nursing homes: A pilot study among professional caregivers. *Journal of Elder Abuse and Neglect*, 13(1), 1-26.
- Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. *Journal of Adult Protection*, 6(3), 15-25.
- Harden, A., & Thomas, J. (2005). Methodological issues in combining diverse study types in systematic reviews. *International Journal of Social Research Methodology*, 8 (3), 257-271.
- Higgins, J. P. T., & Green, S. (2006). Cochrane handbook for systematic reviews of interventions 4.2.6. In *The Cochrane Library* (No. 4). Chichester, UK: Wiley.
- Ito, H., Kurita, H., & Shiiya, J. (1999). Burnout among direct-care staff members of facilities for persons with mental retardation in Japan. *Mental Retardation*, 37(6), 477-481.

- Jogerst, G. J., Daly, J. M., Dawson, J. D., Peek-Asa, C., & Schmuck, G. (2006). Iowa nursing home characteristics associated with reported abuse. *Journal of the American Medical Directors Association*, 7(4), 203-207.
- Jones, J. S., Holstege, C., & Holstege, H. (1997). Elder abuse and neglect: Understanding the causes and potential risk factors. *American Journal of Emergency Medicine*, 15 (6), 579-583.
- Kitwood, P. (1993). Towards a theory of dementia care: The interpersonal process. *Ageing & Society*, 13, 51-67.
- Lachs, M. S., & Pillemer, K. (2004). Elder abuse. *Lancet*, 364, 1263-72.
- Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. In: D. D. Williams (ed.), *Naturalistic Evaluation: New Directions for Program Evaluation*, No. 90. San Francisco: Jossey-Boss, pp. 78-84.
- Manthorpe, J., & Martineau, S. (2011). Serious case reviews in adult safeguarding in England: An analysis of a sample of reports. *British Journal of Social Work*, 41, 224-241.
- Marsland, D., Oaks, P., & White, C. (2007). Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings. *Journal of Adult Protection*, 9(4), 6-20.
- Mills, S. & Rose, J. (2011). The relationship between challenging behaviour, burnout and cognitive variables in staff working with people who have intellectual disabilities. *Journal of Intellectual Disability Research*, 55(9), 844-857.
- Mitchell, G., & Hastings, R. P. (2001). Coping, burnout and emotion in staff working in community services for people with challenging behaviors. *American Journal of Mental Retardation*, 106, 448-459.
- Moore, D. (2001). Friend or foe? A selective review of literature concerning abuse of adults with learning disability by those employed to care for them. *Journal of Learning Disabilities*, 5(3), 245-258.
- Page, C., Connor, T., Prokhorov, A., Fang, Y., & Post, L. (2009). The effect of care setting on elder abuse: Results from a Michigan survey. *Journal of Elder Abuse and Neglect*, 21, 239-252.
- Payne, B. K., & Cikovic, R. (1995). An empirical examination of the characteristics, consequences and causes of elder abuse in nursing homes. *Journal of Elder Abuse and Neglect*, 7(4), 61-74.
- Pillemer, K. (1988). Maltreatment of patients in nursing homes: Overview and research agenda. *Journal of Health & Social Behavior*, 29, 227-238.

- Pillemer, K., & Bracham-Prehn, R. (1991). Helping the hurting: Predictors of maltreatment of patients in nursing homes. *Research on Ageing*, 13(1), 74-95.
- Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, 29(3), 314-320
- Pillemer, K., & Moore, D. W. (1990). Highlights from a study of abuse of patients in nursing homes. *Journal of Elder Abuse and Neglect*, 2(1/2), 5-29.
- Ramsey-Klawnsnik, H., Teaster, P. B., Mendiondo, M. S., Abner, E. L., Cecil, K. A., & Tooms, M. R. (2007). Sexual abuse of vulnerable adults in care facilities: Clinical findings and a research initiative. *Journal of the American Psychiatric Nurses Association*, 12(6), 332-339.
- Reese, P., & Manthorpe, J. (2010). Managers' and staff experiences of adult protection allegations in mental health and learning disability residential services: A qualitative study. *British Journal of Social Work*, 40, 513-529.
- Rose, D., Horne, S., Rose, J. L., & Hastings, R. P. (2004). Negative emotional reactions to challenging behaviour and staff burnout: Two replication studies. *Journal of Applied Research in Intellectual Disabilities*, 17, 219-223.
- Rusch, R. G., Hall, J. C., & Griffin, H. C. (1986). Abuse provoking characteristics of institutionalised mentally retarded individuals. *American Journal of Mental Deficiency*, 90(6), 618-624.
- Sale, J. E. M., & Brazil, K. (2004). A strategy to identify critical appraisal criteria for primary mixed methods studies. *Quality and Quantity*, 38, 351-365.
- Schiamberg, L. B., Oehmke, J., Zhang, Z., Barboza, G. E., Griffore, R. J., Von Heydrich, L., Post, L. A., Weatherill, R. P., & Mastin, T. (2012). Physical abuse of older adults in nursing homes: A random sample survey of adults with an elderly family member in a nursing home. *Journal of Elder Abuse and Neglect*, 24(1), 65-83.
- Sheather, M. (2011). *Serious Case Review Concerning Parkfields Care Home*. Somerset Safeguarding Adults Board.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretive phenomenological analysis in health psychology. *Psychology & Health*, 11, 261-271.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory Method and Research*. London: Sage.
- Sobsey, D. (1994). *Violence and Abuse in the Lives of People with Disabilities*. Baltimore, MD: Brookes.
- Thane, P. (1978). *The Origins of British Social Policy*. London: Croom Helm.

- Trinder, L., & Reynolds, S. (2000). *Evidence Based Practice: A Critical Appraisal*. Oxford: Blackwell.
- Verhagen, A. P., de Vet, H. C. W., de Bie, R. A., Kessels, A. G. H., Boers, M. et al., (1998). The delphi list: A criteria list for quality assessment of randomized clinical trials for conducting systematic reviews developed by delphi consensus. *Journal of Clinical Epidemiology*, 51 (12), 1235–1241.
- Wang, J. (2005). Psychological abuse behavior exhibited by caregivers in the care of elderly and correlated factors in long-term care facilities in Taiwan. *Journal of Nursing Research*, 13(4), 271-280.
- White, C., Holland, E., Marsland, D., & Oaks, P. (2003). The identification of environments and cultures that promote the abuse of people with intellectual disabilities: A review of the literature. *Journal of Applied Research in Intellectual Disabilities*, 16, 1-9.
- Whittington, R. (2002). Attitudes toward patient aggression amongst mental health nurses in the ‘zero tolerance’ era: Associations with burnout and length of experience. *Journal of Clinical Nursing*, 11, 819-825.
- Yuan, Y., & Hunt, R. H. (2009). Systematic reviews: The good, the bad, and the ugly. *American Journal of Gastroenterology*, 104, 1086–1092.
- Zhang, Z., Schiamberg, L. B., Oehmke, J., Barboza, G. E., Griffore, R. J., Post, L. A., Weatherill, R. P., & Mastin, T. (2011). Neglect of older adults in Michigan nursing homes. *Journal of Elder Abuse and Neglect*, 23(1), 58-74.
- Zirpoli, T. J., Snell, M. E., & Lloyd, B. H. (1987). Characteristics of persons with mental retardation who have been abused by caregivers. *Journal of Special Education*, 21(2), 31-41.

2. Empirical Paper

Making Sense of Varying Standards of Care: Front-line Staff Experiences of Working in Residential Care Environments for Adults with Learning Disabilities

2.1 Abstract

Despite a number of health and social care reforms, large inpatient facilities and group homes for people with learning disabilities remain a prominent feature of service provisions throughout the UK. Current evidence suggests that those living in residential facilities are being exposed to considerable variation in the standards of care they receive and recent high profile cases of substandard care and abuse have raised concerns regarding the appropriateness of existing care provisions and practices. While attempts have been made to understand variations in care standards and factors associated with abusive or neglectful practices, there remains a need for more research in this area. Additionally, little attention has been paid to understanding support staff experiences of working in residential or inpatient services and to developing a more theoretical understanding of the role they fulfil. Using Interpretive Phenomenological Analysis (IPA), the aim of this study was to examine front-line staff members' experiences of working in residential care for people with learning disabilities. Six experienced front-line care workers (4 female, 2 male) took part in semi-structured interviews. Interview data was analysed according to the principles of IPA and the following three superordinate themes were identified as being central to participants' experiences of their work related roles: *Degree of Positive Relationship Reciprocity*; *Value Congruence and Intrinsic Motivation*; *Experiences of Environmental and Organisational Constraints*. Results are discussed in relation to existing literature on care standards and the factors associated with abusive or neglectful practices, and in terms of their contribution to theory and applied practice.

Keywords: Staff Experiences, Residential Care, Adults with Learning Disabilities, IPA

2.2 Introduction

As highlighted in the previous chapter of this thesis (Hutchison, this volume), within the last 25 years reforms to services for people with learning disabilities have resulted in an increased emphasis on community-based care and a move away from large scale, segregated, institutionalisation (Mansell, 2006). Consequently, the health and social care sectors have adopted a more inclusive stance and placed greater emphasis on the need to support and care for people at home or in the community (Care Quality Commission: CQC, 2012a). Despite these changes, residential services and larger inpatient facilities still exist within the health and social care structure for people with learning disabilities (Olubokun, 2007). Unlike the large-scale institutions of the past, which embraced a philosophy of generalised care and segregation from mainstream society (Thane, 1978), today's residential services represent more specialised environments aimed at meeting the complex needs of specific individuals that cannot be met in independent living environments. However, as highlighted in the previous chapter of this thesis (Hutchison, this volume), despite these reforms adults with learning disabilities living in residential care environments are being exposed to considerable variation in standards of care. For example, a 2012 national (UK) inspection and review of learning disability services revealed that almost 50% of hospitals and residential care homes did not meet national standards (CQC, 2012b). Additionally, recent high profile cases of substandard care and abuse in residential and inpatient health and social care settings for adults with learning disabilities (e.g. Buckinghamshire County Council, 1998; Department of Health: DH, 2012) have raised serious concerns regarding the appropriateness of existing care provisions and practices. Recent adult protection data also presents evidence to suggest that adults with learning disabilities living in specialist residential care environments may be at greater risk of abuse or neglect compared to those living in community dwellings (Beadle-Brown, Mansell, Cambridge, Milne & Whelton, 2010).

To gain insight into the factors associated with substandard care and/or abuse in inpatient adult health and social facilities, a systematic review of empirical research aimed at identifying causal factors was conducted and presented in the preceding section of this thesis (Hutchison, this volume). The review revealed that research in this area is dominated by studies focusing on the residential care of older adults. While this is likely to be a reflection of the fact that a high proportion of adult residential care facilities are elderly care homes (CQC, 2012a), the review highlights a need for the phenomenon of substandard residential care to be investigated across a range of adult social care settings, including within learning disabilities.

Although research into substandard care practices in residential learning disability services is limited, the review did identify empirical research that has aimed to identify factors and causal processes responsible for abuse and/or neglect in learning disability residential care settings (Cambridge, 1999; Marsland, Oaks & White, 2007; Rusch, Hall & Griffin, 1986; Zirpoli, Snell & Lloyd, 1987). In addition, a number of commentaries and narrative review articles have focussed on the phenomenon of substandard care and/or abuse in residential care environments for adults with learning disabilities (e.g. Furey, 1989; Moore, 2001; Wardhaugh & Wilding, 1993; White, Holland, Marsland & Oakes, 2003). This literature highlights the multidimensional nature of care practices, whereby individual, interpersonal, organisational, environmental and cultural factors are all seen to contribute to the varying standards of care people receive. However, a potential criticism of the current evidence base concerns the fact that it is derived largely from case study evidence (e.g. Cambridge, 1999; McCartney & Campbell, 1998) and post-incident investigation reports (e.g. Buckinghamshire County Council, 1998; Healthcare Commission, 2007). In addition, where more rigorous case controlled designs have been adopted (Rusch et al., 1986; Zirpoli et al., 1987), these studies have focussed on identifying specific service user characteristics that are associated with confirmed cases of abuse. Therefore, research in this field appears to typically adopt a more

objective stance utilising quantitative research approaches, which may neglect the potentially insightful nature of more socially constructed or experiential sources of information. In the previous section of this thesis (Hutchison, this volume) it was concluded that the existing research aimed at understanding abuse in residential care is relatively superficial or descriptive in nature and offers limited theoretical insight into how and why the different factors highlighted above may contribute to substandard care practices. In addition, where attempts have been made to adopt alternative research approaches, such as Grounded Theory (Glaser & Strauss, 1967), further insight was obtained into how some of the descriptive characteristics, identified by other studies, may interact to influence individual care practices (Conlie-Shaw, 1998).

Another potentially important observation regarding the current state of research in this field, concerns the fact that to date the research literature has largely overlooked the experiences of front-line care staff and the potentially unique perspective they may provide. In a recent commentary written by Hastings (2010), it was argued that support staff workers are frequently neglected as a potential focus for research. Specifically, Hastings (2010) highlighted the fact that the quality of work of these staff members directly impacts overall care standards and quality of life outcomes for service users. In addition, investigations into sub-standard care and abuse typically highlight ‘problematic’ behaviour of support staff as a central factor or primary cause for concern (e.g. Buckinghamshire County Council, 1998; Healthcare Commission, 2007). Despite this, research has paid little attention to understanding support staff experiences of working in services for people with learning disabilities.

Consequently, the aim of this study was to adopt a phenomenological stance to examine front-line staff experiences of working in residential care for people with learning disabilities. Specifically, this investigation explores how experienced care staff perceive and make sense

of their role in relation to both past and current practice and any organisational/policy initiatives aimed at improving services. It was anticipated that this would complement existing research in this field and provide valuable insight into some of the processes responsible for differing care standards and practices in learning disability residential care settings.

2.3 Method

2.3.1 Methodology

Interpretive Phenomenological Analysis (IPA: Smith, 1996; Smith, Flowers & Larkin, 2009) was identified as an appropriate methodology for this study. IPA recognises the importance of personal experience and is concerned with people's personal perceptions or accounts of an object or event (Smith & Osborn, 2008). Consequently, it is less concerned with attempts to produce objective statements about the object or event in question and allows for more experiential and socially constructed forms of meaning to emerge (Smith & Osborn, 2008).

2.3.2 Sampling Strategy

With institutional research ethics approval (See Appendix B.1), a purposive sampling strategy was adopted to identify and recruit potentially eligible participants. Within IPA based research, it is common practice to identify a fairly homogenous or closely defined sample of participants for whom the research question is considered highly significant (Smith, Flowers and Larkin, 2009; Smith & Osborne, 2008). Consequently, the following inclusion/exclusion criteria were applied:

- Adults (aged 18+)
- Currently employed as an unqualified (i.e. support worker or healthcare assistant) member of care staff
- Employed in residential services for adults with learning disabilities

- Possess a minimum of five years' experience of working in the above setting and role

Participants were recruited using a combination of methods. First, messages were posted on on-line health and social care forums inviting support workers to share their experiences of working in residential learning disability services. In addition, once an initial sample of participants had been recruited, snowball or referral sampling was adopted to identify further eligible participants. Specifically, early participants were invited to identify potential future participants from among their own acquaintances.

2.3.3 Participants

Six front-line care workers (4 female, 2 male) volunteered to take part in a single semi-structured face-to-face or telephone interview. Participants were aged between 28 and 52 years and had between 5 and 24 years of experience of working in residential care for adults with learning disabilities. For an overview of the sample recruited, see Table 2.1.

Table 2.1 Overview of sample characteristics

| Participant | Gender | Age | Years of Experience | Interview Mode |
|--------------------|---------------|------------|----------------------------|-----------------------|
| 1 | Female | 35 | 7 | Face to face |
| 2 | Male | 52 | 18 | Telephone |
| 3 | Male | 41 | 8 | Telephone |
| 4 | Female | 28 | 5 | Telephone |
| 5 | Female | 45 | 23 | Face to face |
| 6 | Female | 42 | 24 | Face to face |

2.3.4 Procedure

All those recruited were sent a participant information sheet (See Appendix B.2) and consent form (See Appendix B.3) to sign and return. Prior to consenting to take part in the study, all participants had the opportunity to ask the chief investigator any questions about the research and their potential involvement in it. During the consent process, participants were also asked to indicate their preferred interview mode. While it has been suggested that important aspects

of the interviewer/interviewee relationship (e.g. visual cues) can be lost over the telephone (Donovan, Hollman, Corti & Jalleh, 1997), research evidence within health and social science has generally demonstrated that telephone interviews are comparable to face-to-face interviews across a range of research settings and approaches (e.g. Bailey, 2008; Greenfield, Midanik & Rogers, 2000; Rohde, Lewinson & Seeley, 1997).

2.3.5 Interview Process

As the aim of this research was to explore participants' experiences and understand how they made sense of their role, semi-structured interviews were used to ensure a relatively flexible approach to the data collection process. It is generally accepted that this form of interviewing allows for a dialogue between researcher and participant, which is both focused on a general goal (i.e. understanding a person's lived experience) and sensitive to individual variation (Smith & Osborne, 2008). Specifically, a semi-structured approach allows for the researcher to probe around potentially interesting information that arises and permits questions to be modified based on participant responses. For the purposes of this study, interviews attempted to encourage participants to talk freely about their experiences of working in residential care, with specific emphasis on exploring any experiences of change and differences in care practices they had encountered. To guide this process an interview schedule was developed (See Appendix B.4). All interviews were conducted by the principal researcher and due to their semi-structured nature, interviews varied in length, from 41 minutes to 63 minutes (mean = 51.3). The semi-structured interview approach to data gathering also allowed for a process of member checking, whereby the interviewer was able to restate or summarise information and then question participants to determine the accuracy of any initial interpretations. All interviews were digitally recorded using an Olympus DM 650 digital voice recorder and then transcribed verbatim.

2.3.6 Analysis

Interview data was analysed according to the principles of IPA (Smith, 1996; Smith & Osborne, 2008; Smith, Flowers & Larkin, 2009). All transcripts were first analysed on a case-by-case basis. For each case the process involved an initial detailed examination, whereby each transcript was read multiple times and annotated/coded for seemingly interesting/significant observations or insights. Initial notes or codes generated were then reviewed and transformed into themes, in order to move the analysis to a higher level of abstraction (See Appendix B.5 for an extract from one of the annotated transcripts showing both initial codes/annotations and subsequent themes). For each case, themes were then examined for possible connections and clustered accordingly to help identify higher order themes. A key characteristic of the IPA approach concerns the fact that it is iterative in nature and therefore involves a continual interaction between the researcher and the source material/text (Smith & Osborne, 2008). Therefore, as initial themes, clusters and higher order themes were identified, these were continually checked with the relevant interview transcript to ensure they remained consistent with the data source. A detailed record of the analytical process was kept throughout, which represented a step by step descriptive account of the analysis and the specific techniques used to review, cluster and refine the themes generated (See Appendix B.6 for an extract of that document). A key technique used to facilitate this process was the creation of summary tables which were populated by emergent themes. To assist with the examination and clustering of themes, colour categories were also created to indicate observed similarities or differences between themes. These subsequently facilitated the identification of possible higher order categories (See Appendix B.6 for a detailed description of this process). As additional cases were analysed, attempts were made to identify repeating patterns (between cases) while still allowing the analysis to remain open to new emergent interpretations. Where new interpretations did emerge, earlier transcripts were

reviewed to explore whether or not they provided additional insight into the newly identified themes. Once each transcript had been analysed, a final table of superordinate themes (See Table 2.2) was constructed, which outlines the identified meanings inherent in the participants' experiences.

2.4 Results

Based on the analytic process described above, three superordinate themes were identified from the raw interview data. Table 2.2 provides an overview of the themes identified and the related sub-themes, from which they were derived. A detailed summary of each theme is then provided, alongside relevant raw data extracts².

Table 2.2 Summary of themes relating to front-line staff experiences of their role

| Superordinate Themes and Related Sub-themes |
|---|
| <p><i>Theme 1: Degree of Positive Relationship Reciprocity</i></p> <ul style="list-style-type: none"> • Feeling valued & empowered vs Feeling undervalued & powerless • Collaborative team working vs Isolated working • Relationships that provide intrinsic reward • Inequality & pathologising vs Equality and recognition of “personhood” <p><i>Theme 2: Value Congruence and Intrinsic Motivation</i></p> <ul style="list-style-type: none"> • Intrinsic vs Extrinsic motivation • Degree of congruence between own values & priorities & positive care principles • Stimulation vs Boredom <p><i>Theme 3: Experiences of Environmental and Organisational Constraints</i></p> <ul style="list-style-type: none"> • Isolated or segregated services vs Accessible integrated services • Clear leadership & guidance vs Inconsistency & uncertainty |

2.4.1 Theme 1: Degree of Positive Relationship Reciprocity

Throughout the data analysis process, themes consistently emerged which were related to quality of participants' relationship experiences with colleagues, service users and managers.

² Each quote contains a reference to the case it was extracted from and its location in the relevant transcript.

Specifically, these themes appeared to account for the extent to which participants experienced their relationships as reciprocal mutual exchange of privileges, rewards or positive actions. These experiences were captured by the following sub-themes:

1a. Feeling valued and empowered vs Feeling undervalued and powerless

During the course of each interview, all participants spoke about their experiences of relationships with managers or senior colleagues. In relation to this, they often referred to the extent to which they felt valued and empowered by those more senior to them. For some, these relationships were described in a very positive light. Typically, such experiences were characterised by the feeling of being listened to and having an opinion that counts:

“Well I’ve been fortunate that I have had good managers....Yeah, that listened and took on board what you thought as a member of staff, because you were the one who worked closely with the service users” [6.241]

“...and the managers will take everything on board” [1.551]

“If the manager took upon it, and then listened to what you said and then acted, it made life perfect, I mean really and truly” [6.252]

One participant also spoke positively about the experience of being encouraged to collaborate with a senior colleague and in doing so contribute her own knowledge and expertise:

“And I worked along with my manager, even though it wasn’t in my remit, but my manger asked me to help out with doing the bid. So he and I worked very hard together on writing up this bid to send to the local authority” [4.513]

However, for many of the participants, relationships with senior colleagues were experienced in a much less positive light and were characterised by feelings of being disregarded or made to feel worthless and powerless by senior colleagues:

“...everyone I work with at the moment feels very undervalued” [2.100]

“...she [the manager] said ‘there’s no way we are going to be able to give you a pay rise because I don’t think that any of you are worth it’

and she said 'if you don't like it, there's the drive, there's the door and just go'” [2.241]

“None of our opinions count” [3.192]

This, in turn, appeared to impact on the extent to which participants felt able to offer an opinion or act autonomously in their roles:

“I was the only one who stood my ground and I was made to feel like a shit bag” [3.738]

“We are not allowed to do our jobs. We've got some fantastic NVQ 3's working with us, who are more than capable, but it goes down to our boss, who, seriously I think she was born in the Stalin era” [3.211]

“...it's their [the management] way or the highway. The amount of times we have to go along with things, it just keeps the peace, which is really frustrating” [3.196]

“...we were all allowed to remain in our jobs in the care home although if we didn't agree with their terms and conditions we were told that we had to leave basically. So it was a choice between losing our jobs or remaining in the work that we really enjoyed” [4.38]

1b. Collaborative team working vs Isolated working

Another prominent narrative that appeared to relate to relationship reciprocity was concerned with the degree to which participants' experienced their relationships with colleagues as collaborative and described feeling part of an equal and close knit team:

“...you feel very much part of a little community or family” [1.180]

Where participants did allude to such experiences, they also described what they perceived as the benefits of close team working (i.e. reduced staff sickness, enjoyment, positive work outcomes) and referred to specific processes (i.e. team meetings & team building activities), which they felt facilitated that level of relational closeness and collaboration with colleagues:

“And nobody went sick because we were such a good support team within ourselves....Support workers and your manager. They all supported each other, yeah, so there was no sickness. None at all” [6.278]

“...we’d all meet at least once a month if not twice a month, to have a great big meeting. And I remember, this led to one of the bosses bringing in a policy about pregnancy” [3.50]

“...now and again we have team building days which is fantastic...Um, we had to do all these different kinds of activities together and do things in groups...So you get to know a bit more about the people you are working with” [5.164]

However, while the majority of participants alluded to the potential benefits of close, collaborative working relationships, many of the interview narratives were dominated by experiences of feeling more isolated and references to perceived barriers to collaborative ways of working. These included references to a lack of team meetings and experiences of senior colleagues refusing to share information:

“So we are a company. Surely we should be having meetings together because we can float between each house, wherever she wants to put us. So you’d think, you know, that we should be able to keep our finger in the pie, so to speak. But again, she won’t. It just baffles the living shit out of me, it really does” [3.348]

“...she does just not like to share, and she comes in, and she just blows up and say’s how we’re all thick and stupid. And it’s like wow hang on a minute, if you’d given us some information, we could deal with the situation better. But they will not do it and nobody knows why” [3.331]

One participant also alluded to the potential influence that the physical work environment may have on a staff member’s ability to work closely with colleagues:

“...it’s closer here, because I see most of them nearly every day. Whereas in a hospital there’s, err you might see someone sort of once or twice a week. You don’t really know them” [5.404]

1c. Relationships that provide intrinsic reward

Participants often spoke about their relationships with the service users. A prominent theme that emerged from those narratives was the extent to which participants valued and were able to obtain intrinsic reward from interactions with service users. This typically involved them

experiencing a sense of getting something back from the service users, often in the form of positive actions or a sense of achievement/competence:

“When I can walk away from my job at the end of the day and say, you know, so and so is fine, they’ve done this, they’ve done that and they’re happy, so that’s it...Yes I have, I’ve had those experiences. You know, um, and I get positive feedback from the service user...That is one of the main things. Yeah, and I know that I done damn good job that day, you know?” [6.571]

“You’d go in in the morning and she could stand there, arms wide open, and give you the biggest hug on the planet. And it just makes all that nastiness, that we went through for months and months and months, just completely melt away because you’ve got that tiny connection ... it’s just those little windows...A little bit of positive, which is just,...they’re just amazing” [3.250]

“... when you have spent a lot of time with them and sat with them and have given them some control over their own lives, for them to come and sit with you in the office and want to spend time with you, I mean that’s a huge big deal, I mean someone wants to spend time in your company, um, and that’s people who are verbal and mobile. Someone offering to make you a cup of tea, I mean that’s always lovely” [4.218]

However one participant also alluded to the fact that, based on her experiences, a service user’s level of impairment could potentially limit the extent to which it might be possible to obtain such intrinsic rewards:

“...that is a hugely difficult service to work in, a service for people who have PMLD [Profound & Multiple Learning Disabilities]. Um, because you don’t get, because the rewards are so subtle, you know, it’s not that they are not there, the rewards are there, you just have to be very finely attuned to the way people behave” [4.250]

1d. Inequality and Pathologising vs Equality and Recognition of “Personhood”

The final emergent sub-theme concerned with relationship reciprocity, was again related to participants’ experiences of relating to the service users they worked with. Specifically, when asked, the majority of participants equated quality of care with the extent to which they related to service users as equals and were able to recognise their individual needs and differences:

“I have my choice, so they have a right to choose” [1.115]

“...us, as support workers, would try to give them as much independence and normal life and freedom of choice, and being able to live as everyone else and have the same choices in life, and have a normal life” [1.78]

“...Quality care. Well, to treat somebody how you would want to be treated yourself...With respect and dignity” [3.459]

Where participants described experiences of inequalities between staff and service users, this was consistently viewed as problematic:

“I am a great believer in person centred, and you know, if we are not getting that sort of approach, err ..., then I’d say there’s a big problem there, a big problem straight away” [2.392]

“You wouldn’t want to get in a bath with someone else’s stuff [reference to water used by another service user] in do you? No? Would you do it? Absolutely not, so why should these guys?” [3.569]

One participant also described experiencing situations where his management were actively reinforcing such inequalities:

“...they should be regarded like they understand everything, not as if they don’t understand what we’re talking about....It’s as if we are talking to them and they are not there, sort of thing, and that’s not right. I know that they understand. They understand a lot more than what our bosses think” [2.151]

Acknowledgment of the importance of recognising service users’ individual needs and differences were also evident in some participants’ experiences of being confronted with behaviour that might be perceived as challenging. Specifically, participant narratives suggested that the extent to which situations are perceived as challenging and any resultant staff actions, are influenced by the degree to which service users’ individual needs and their ability to make choices are considered:

“...people say challenging behaviour is because they are autistic, or whatever, ..., no challenging behaviour is a form of communication. They are telling you that they are unhappy about something and it is

your job as a manager or as a care worker to find out what they are unhappy about and support them through it” [4.488]

“And I’ve worked with clients who have been, had severe challenging behaviour...Why am I going to pin somebody down on the floor with so much force, when really and truly all I have to do is open the door and go through it [laughs] you know?...Because at the end of the day, this is their home. If they decide to break it, break a window or break a vase, it can easily be replaced....Sometimes they’re just venting their frustration or whatever. I don’t see the reason why I should bring someone to the floor” [6.333]

2.4.2 Theme 2: Value Congruence and Intrinsic Motivation

The data analysis process also revealed that participants frequently alluded to variations in the extent to which they experienced their role as being consistent or congruent with their underlying values and priorities, and the subsequent extent to which they were able to obtain intrinsic reward from their work. These experiences were captured by the following sub-themes:

2a. Intrinsic vs Extrinsic motivation

A prominent theme from participants’ accounts of their roles was the extent to which they felt intrinsically motivated and personally valued their work. Where participants alluded to experiencing a high level of intrinsic motivation towards their work role, this was typically characterised by enjoyment, personal satisfaction or a sense of achievement derived from their work. A number of participants also described experiencing their work role as fitting or being congruent with them as a person:

“I feel like I am making a difference... And if I do this job, I feel like ‘yes, I’ve done something good today’ and I maybe changed someone’s life for one day” [1.300]

“I thought well I like being with people, and I thought well ok.....So I thought ‘right, let’s have a go at that then.’ And I enjoyed it and have been doing it ever since” [2.592]

“...it was very clear within one or two days of my starting working there that this was the job that I was going to be fantastic at, that I was going to really excel at” [4.95]

However, participant narratives also alluded to the fact that care staff do not always experience a high degree of intrinsic motivation towards their work roles and that intrinsic motivation and reward can be difficult to maintain over time. Typically, this was viewed as a cause for concern among participants:

“So we’ve had these people come to us and they are seriously not interested in the job whatsoever ..., and they’ve said ‘oh I wish I could get out of this place, I could have my rent paid for and my council tax’” [2.355]

“You’re just going to work for the sake of work...to pay the bills. And that’s the last thing that you need. Because you have to have some passion, working in the care field, or some kind of empathy. Yeah, but that seems to leave you” [6.654]

“...well you’ve got to be a caring person anyway haven’t you? I am a caring person ..., I have got lots of patience...I’m good at listening. I’ve got all the qualities there but it’s becoming like it’s not as important for me anymore” [5.283]

2b. Degree of congruence between own values and priorities and positive care principles

The extent to which participants described experiencing their roles as intrinsically motivating or congruent with their own values, also appeared to be related to the extent to which their own priorities were closely aligned with positive care principles:

“I really wanted this challenge of working with people and for people” [1.245]

“I guess I always found working with people directly more suited to my personality. And I’ve always had err, quite a caring, ... err, and interest in psychology and counselling, but quite a caring attitude, um, towards people in general” [4.87]

“...it’s not just my job, it’s part of who I am” [1.301]

However, participants also described experiencing considerable concern regarding the extent to which they were able to conduct their work according to those positive principles:

“I think the care sector I think, you know ..., I do find that it’s failing slowly now. I think the whole care sector is failing I think and err, I’d like to think that it is one of the best jobs to be in, you know. I still think there’s hope, that there’s a chance that it could be one of the best jobs out” [2.7]

“...because of staffing ratios as well, you’re not able to take that person out into the community” [6.93]

“I’ve seen a dwindling of finances within the service as well. The homes itself, there was, when I first started there wasn’t a cap on say the amount that you spent on activities. Everything was geared around the comfort and the wellbeing of the service user, you might also say. And there was nothing that they were denied” [6.422]

2c. Stimulation vs Boredom

Value congruence and intrinsic motivation was also associated with the extent to which participants experienced their roles or specific tasks as cognitively or intellectually stimulating or not:

“To be honest I enjoy every aspect of my job...I always have done because if I didn’t then I wouldn’t be in it for this long to be honest” [3.103]

“...I always found planning the activities more enjoyable than the activity itself funnily enough, because planning is where you find you get to have these really in depth conversations,.. look through holiday brochures and fliers from the theatre and err, you know, find out what the person really enjoys” [4.372]

“...well I think the best part is when we get to involve the residents in activities. For example, because I love singing. For me singing with the residents, I have to do that every time I am on shift.” [1.162]

However, while many of the participants were able to cite specific work roles, which they experienced as stimulating, some of them also alluded to that fact that their work role can lack that stimulation. Specifically, participant narratives alluded to a sense that work could be experienced as repetitive and monotonous, and that this was a noticeable source of frustration for participants:

“I feel like sometimes, every day is just the same...Um, it’s more mentally it drains you than physically” [5.156]

“It is frustrating. And to tell you the truth, it just becomes monotonous and it’s like you’re on a treadmill” [6.653]

“...doing the same job every day. I found that really boring” [1.244]

2.4.3 Theme 3: Experiences of Environmental and Organisational Constraints

Finally, the data analysis process revealed that participants’ experiences of their roles were frequently characterised by an awareness of various environmental and/or organisational constraints. This was captured by the following sub-themes:

3a. Isolated or segregated services vs Accessible integrated services

A prominent sub-theme within this category related to the extent to which participants experienced the services, within which they worked, as being isolated from mainstream society. Typically, participants’ experiences of more isolated environments were described in a more negative light. For example, one participant commented about her previous workplace that:

“It reminded you of some of those films you see on the telly. Really they [the service users] are just forgotten about. Do you know what I mean?” [5.72]

To emphasise the potential difficulties that can arise as a result of isolated services, another participant, when asked about care standards, commented that:

“I certainly wouldn’t go on the basis of how many complaints you receive because, you know, complaints are never really made in these places” [4.638]

The extent to which participants experienced their work environments as being isolated or segregated from mainstream society, versus experiencing them as being well integrated with society, also appeared to be related to the size of the service. Specifically, it was typically felt that smaller services facilitated a greater degree of integration:

“And I’ve worked in smaller units as well where there are two or three Yeah, service users. And those were really, really good because obviously with the interaction that you had with the service users, you got to know them a lot better and you got them to integrate within the community as well. So they were able to access everything. So yeah, their life was practically perfect you know?” [6.110]

“I can see the difference how the residents are treated when they live in a small environment, in a smaller house, than when they live in a big massive place with less stuff. The attention, the support, the opportunities you can provide,...So, um, I think there is a massive difference, working for a big company or for something smaller” [1.13]

3b. Clear Leadership and Guidance vs Inconsistency and Uncertainty

From an organisational point of view, participants also frequently spoke about the extent to which they experienced clear leadership and guidance while in their work roles. In relation to this, only one participant described feeling consistently well supported by her management, which she perceived as being relatively unusual:

“Very well supported, very very well. And I don’t have enough words to express my gratitude towards my managers because what they are doing and what they have built up, it’s fantastic. You really can’t find the same sort of environment in many places I don’t think.” [1.532]

Typically, participant narratives alluded to inconsistencies in people’s work experiences, with regards to the leadership and guidance they had received. This, in turn, seemed to be associated with a sense of mistrust and uncertainty:

“But then you get a manager who kind of comes in, and wants to put their stamp on everything and introduce new ways of working, in terms of paperwork and filing, you end up with having to fill in ten or eleven different sheets of paper every time you finish a shift” [4.430]

“It’s that type of grey area...., and yet back in my last role we had very clear guidelines on those things” [3.808]

“There’s always these hurdles, you know, these bosses, they seem to..., if they can slow things down or bring things to a halt for a certain length of time, then they know they’ve got you then” [2.645]

“The management are playing cat and mouse with the staff” [2.213]

In relation to this, participant narratives alluded to the importance of training and the sense of security and clarity that it can provide them with:

“...You can do like half a day course or a two day course...Um, it also covers DOLS, which is deprivation of liberty act. I think they scrapped that quite recently. ..., you know, it helps us to think about how we talk, how we address a resident, how we conduct ourselves in front of a resident” (3.783)

“That’s when you see poor quality of care because people don’t know what to do....I’ve seen it yeah, I’ve seen it. Um, and you have it with um, lack of training inadequate training. Most organisations have their training, but it’s not adequate” [6.316]

2.5 Discussion

The aim of this study was to examine front-line staff members’ experiences of working in residential care for people with learning disabilities. As a result of the IPA process described, three superordinate themes were identified as being central to participants’ experiences of their work related roles: 1. *Degree of Positive Relationship Reciprocity*; 2. *Value Congruence and Intrinsic Motivation*; 3. *Experiences of Environmental and Organisational Constraints*. Due to the fact that this thesis is concerned with making sense of varying standards of care, attempts are made throughout the discussion to consider how the phenomenological data presented may contribute to the existing literature on care standards and the factors associated with abusive or neglectful practices. Results are also discussed in terms of their potential contribution to future applied practices.

2.5.1 Theoretical Implications

The first superordinate theme that emerged as being central to participants’ experiences was defined as the *Degree of Positive Relationship Reciprocity*. This related to the quality of participants’ relationship experiences with colleagues, service users and managers, and described the extent to which they were perceived as reciprocal mutual exchanges. Within the wider literature, which has focussed on a range of services and industries, the concept of

mutually beneficial or equitable relationships between individuals (e.g. service users), workers/employees (e.g. carers) and employing organisations (e.g. care providers), has attracted considerable research attention (e.g. Alexander & Charles, 2009; Dabos & Rousseau, 2004; Duffy, Oyebode & Allen, 2009; Rose, Madurai, Thomas, Duffy & Oyebode, 2010; Van Horn, Schaufeli, & Taris, 2001). This relational construct is typically referred to as mutuality or reciprocity and has been shown to be associated with a number of positive outcomes such as: increased productivity (Dabos & Rousseau, 2004), greater occupational commitment (Duffy et al., 2009) and reductions in staff/employee burnout (Van Horn et al., 2001). Conversely, a lack of reciprocity has been linked to less favourable outcomes (e.g. emotional exhaustion: Rose et al., 2010). Therefore, existing literature supports the observed significance of participants' experiences of relationship reciprocity and highlights the potential for it to impact on factors such as staff wellbeing and care practices.

Within the context of residential care for people with learning disabilities, Thomas and Rose (2010) have explored the concept of reciprocity and produced evidence to suggest that it may impact on the emotional and behavioural responses of staff. Specifically, their research suggested that a lack of perceived reciprocity in staff relationships with service users, their employing organisation and their work colleagues, was related to burnout and emotional exhaustion. This, in turn, was found to be associated with increased negative emotion, decreased positive emotion, reduced optimism and reduced likelihood of applying extra effort (Thomas & Rose, 2010). Therefore, Thomas and Rose's (2010) findings appear to demonstrate that a lack of reciprocity has the potential to impact negatively on both staff wellbeing and care practices. Consequently, this appears to highlight that the interpersonal needs of staff members working in residential services should not be overlooked. Specifically, the extent to which staff members are able to experience positive mutual exchanges with colleagues, service users and the wider organization may represent an important determinant

of staff wellbeing and levels of commitment to their roles. Additionally, reciprocity may be an important variable to consider when attempting to understand the contribution of interpersonal factors to variations in care standards.

The second superordinate theme identified as being central to participants' experiences of their work roles was termed *Value Congruence and Intrinsic Motivation*. This accounted for the extent to which participants were able to experience their roles as being consistent or congruent with their underlying values and priorities, and the degree to which they were able to obtain intrinsic reward from their work. In relation to this, there is a considerable body of psychological literature exploring the phenomenon of human motivation. Within this, distinctions have been made between different levels and types of motivation. The most basic distinction differentiates between intrinsic and extrinsic motivation, to refer to the extent to which a person does something because it is inherently interesting versus doing something because it leads to a separable outcome (Ryan & Deci, 2000). Within the current study, considerable variation was evident in the extent to which staff experienced intrinsic motivation towards their role and found it intellectually stimulating and consistent with their underlying values. For example, some participants alluded to the importance that they personally ascribed to being able to make a difference to others and described an inherent enthusiasm and sense of satisfaction towards their work. However, participants also described experiencing or witnessing in others, a lack of enthusiasm for their role and motivation centred solely on obtaining extrinsic rewards (e.g. to earn a wage).

Within the literature comparisons have been made between people whose motivation for a particular action is more intrinsic compared to those who are more extrinsically motivated (Ryan & Deci, 2000). This has demonstrated that intrinsically motivated actions are typically associated with a higher degree of interest, excitement and confidence, which in turn can be associated with enhanced performance, creativity, commitment and wellbeing (Nix, Ryan,

Manly & Deci, 1999; Ryan & Deci, 2000; Sheldon, Ryan Rawsthorne & Ilardi, 1997). Therefore, existing literature in this area appears to offer some insight into why degree of value congruence and/or intrinsic motivation appeared to represent such a prominent theme in relation to participants' experiences. Additionally, this would suggest that variations in the extent to which care staff experience intrinsic motivation towards their role, may impact on factors associated with care standards and practices (i.e. performance, level of commitment, wellbeing). This is also consistent with previous research into the causes of substandard care, whereby motivational characteristics (e.g. low job satisfaction & negative attitudes towards work) have been identified as possible risk factors (Goergen, 2004; Marsland et al., 2007; Pillemer & Moore, 1989, 1990).

The final superordinate theme identified as being central to participants' experiences was termed *Experiences of Environmental and Organisational Constraints*, which accounted for specific organisational and environmental factors that featured notably in the data. Within this a prominent sub-theme accounted for the extent to which participants appeared to experience the services within which they worked, as being isolated or well integrated with mainstream society. In relation to this, experiences of larger, more isolated environments were typically described in a more negative light and viewed as restrictive and detrimental to the service users involved. Conversely, smaller residential environments were experienced by participants as being less restrictive and better equipped to meet the individual needs of service users. This appears to reflect well publicised concerns regarding the potential for segregated institutionalised care to be detrimental for service users (Stanley, Manthorpe & Penhale, 1999). Closer inspection of the data is also reflective of the cultural changes that occurred as a result of those concerns (i.e. a shift from large scale institutionalised care to community living and smaller group homes). Specifically, where participants did reflect on experiences of isolated, segregated environments, these were typically references to past as

opposed to current work roles. Therefore, participant experiences appear to offer support for the contention that smaller, well integrated care environments promote greater independence and self-determination in service users and provide better opportunities for more personalised care (Van Loon & Van Hove, 2001).

Size of care environment was also implicated by participants as a factor that influenced the extent to which they experienced clear and consistent leadership and guidance in their work roles. This represented the second sub-theme relating to environmental or organisational constraints. Specifically, despite emphasising the value of close supportive management, participant experiences were frequently characterised by inconsistencies in the leadership and training/guidance they received. This was particularly the case in larger staff teams where management were perceived as being more disparate and less available. This is consistent with the findings of a recent independent review into healthcare assistants and support workers in the NHS and social care settings (Cavendish, 2013), which concluded that the quality of training and support that care workers receive varies considerably. As highlighted in the previous chapter of this thesis (Hutchison, this volume), factors such as ineffective staff support/supervision, dissatisfaction with management and a lack of training/guidance, have all been identified as potential risk factors or causes of substandard care (Cambridge, 1999; Goergen, 2004; Payne & Cikovic, 1995; Wang, 2005). Consequently, the lack of consistency and guidance, reported by participants, raises serious concerns about the appropriateness of existing training and support systems and current leadership practices.

2.5.2 Implications for Practice

The results of this research echo previous calls by Thomas and Rose (2010) for interventions to be considered, which address the perceived equity of care staffs' relationships with their employing organisation, their colleagues and the service users they work with. Therefore, services should consider methods of enhancing reciprocity and collaborative working

relationships. This could involve the implementation of negotiated key-worker relationships, whereby individual service users are paired with a member of staff who is responsible for working closely with them to help empower and enable them to have greater control over their lives (Bland, 1997). Arguably, these types of working alliance between staff and service users should facilitate greater insight by staff into the individual needs of services users and provide opportunities for staff members to obtain intrinsic reward (or a sense that they are getting something back) from their work (i.e. a sense of achievement). To promote more equitable and effective working relationships within staff teams, services are encouraged to consider methods of facilitating greater role clarity, the development of shared goals/a shared sense of purpose, effective communication, and mutual respect (Mickan & Rodger, 2005). This may include regular team meetings, structured team building, organised social activities and staff away days.

The results of this study also present a case for the implementation of regular clinical supervision for front-line support workers. Specifically, regular supervision has been associated with increases in staff morale, improved interdisciplinary communication, reductions in staff burnout levels and improved standards of care (Jones, 1999; White et. al., 1998; White & Winstanley, 2010). It has also been argued that clinical supervision may be particularly beneficial in light of recent changes to the nature of healthcare delivery in the UK (Butterworth, Bell, Jackson, & Pajnkihar, 2008). Specifically, it has been highlighted that staff are increasingly being given more responsibility, greater autonomy and are expected to work more independently, which has resulted in an inevitable reduction in their available support mechanisms (Hyrkas, Koivula, Lehti, & Paunonen-Ilmonen, 2003). Therefore, clinical supervision could be used to enhance staff members' experiences of interpersonal relationships with senior colleagues and facilitate greater support/guidance, which may in turn impact positively on care practices.

Lastly, the results of this study have highlighted possible implications for the recruitment of staff into residential facilities for people with learning disabilities. Specifically, when recruiting staff, attention should be paid to the extent to which people are intrinsically motivated to work in care, as their levels of motivation may be reflected in their commitment to their roles. This also echoes the implications of a recent independent review (Cavendish, 2013), which emphasises that, in order to get good quality care, the right kind of people need to be recruited into carer roles. Therefore, this may necessitate a more rigorous selection and recruitment process, which is sensitive to applicants underlying values and priorities and the degree to which those values are congruent with the demands of working in care. However, this may be difficult to achieve without significant reforms to the care sector, as it is well publicised that staff working in residential services are often in receipt of very low wages (Pennycook, 2013). Specifically, in order to attract a high proportion of intrinsically motivated staff, care work may need to become a more financially viable career option.

2.5.3 Limitations and Future Research Directions

Although attempts were made to identify a homogenous or closely defined sample, there was considerable variation in the years of experience that each participant possessed (this ranged from 5 to 24 years). This represents a potential limitation of the present study because, within the last 25 years, reforms to services have resulted in a number of changes to the health and social care provisions for people with learning disabilities (Mansell, 2006). Therefore, this may limit the extent to which the phenomenological data presented is reflective of current care settings. However, during each interview participants were encouraged to reflect on changes that they had experienced over the course of their working careers. While this did elicit differences in participants' experiences at different times in their careers, these were typically captured as variations within the different themes and analytic categories identified. For example, one participant referred to differences in the extent to which she experienced

reciprocity with colleagues when she reflected on her previous work in a large scale institution.

Another potential limitation relating to the design of the present study, concerns the potential for findings to be influenced by a sampling or recruitment bias. Specifically, the purposive sampling strategy adopted, whereby potential participants were required to express an interest in taking part, may have resulted in a specific type of care worker being recruited. For example, it could be argued that those who express an interest in being involved in research relating to their work are more likely to possess greater interest and motivation towards it. Consequently, limited insight may have been gained into the experiences of those less committed to working in care and the subsequent impact this may have on care standards. This may also account for the limited references that were made to experiences of substandard care practices, despite the fact that understanding variations in care standards was a focus of this research. Consequently, future phenomenological research into the experiences of those less motivated for careers in care may be warranted.

2.5.4 Reflections on the Researcher's Role in the Process³

Although IPA attempts to place the experiencing participants at the centre of the research endeavour, it also acknowledges that the researcher plays a significant part in the interpretive process (Biggerstaff & Thompson, 2008). Therefore, while IPA researcher's attempt to suspend presuppositions and judgements, in order to focus on what is actually being presented in the data (Smith & Osborne, 2008), they are also encouraged to actively reflect on their role in that process. Prior to my career in clinical psychology I was employed in a number of support worker roles, in order to gain relevant clinical experience and improve my future career prospects. Therefore, when I embarked on this research project I possessed my own lived experience of working as a member of unqualified care staff, which I feel contributed to

³ Because this paragraph reflects on the contribution of the principal researcher, the first person pronoun is adopted throughout.

me developing an interest in this area of research. Additionally, although my previous work was in mental health and addictions settings, some of the experiential data captured during this study did resonate with my own experiences. However, to minimise the potential for my own experiences to be reflected in my interpretations of the interview data, the analysis involved a continual interaction between myself and the source data/text. As explained previously this iterative process is a key characteristic of IPA and can help to minimise undue sources of bias (Smith & Osborne, 2008). Additionally, samples of my data coding and higher order themes were reviewed by my academic supervisor who was able to comment on the extent to which they appeared consistent with the participant's accounts of their experiences.

2.6 Conclusions

This study has presented an Interpretive Phenomenological Analysis of staff experiences of working in residential service for people with learning disabilities. The emergent themes identified emphasised the potential significance of interpersonal relationships (*Degree of Positive Relationship Reciprocity*) individual motivational characteristics (*Value Congruence & Intrinsic Motivation*) and wider environmental or systemic factors (*Experiences of Environmental and Organisational Constraints*). The rationale for conducting this research emphasized the potential for it to generate further insight into the factors associated with varying standards of care in residential services. Consequently, results were discussed in terms of how they might contribute to existing literature in that area. In relation to this, front-line staff members' experiences of their roles appear to map onto the range of factors, which were identified in the previous chapter of this thesis (Hutchison, this volume) as impacting on care standards and practices (i.e. those that operate at a cultural or organisational/ environmental level and those that operate at an individual or interpersonal level). However as previously highlighted, existing literature has been criticised for being largely descriptive in

nature and offering limited theoretical insight into how and why different factors may impact on care standards (Hutchison, this volume).

Arguably, by considering the results of this study alongside the existing literature, this research has been able to provide an additional level of explanation into how and why cultural, organisational and/or interpersonal factors may influence standards of care and practices. Specifically, it has highlighted the potential role of relational constructs, such as mutuality and reciprocity and emphasised the impact that individual motivational characteristics can have on care dynamics. Ultimately, it is felt that this research has raised some important theoretical and applied implications and demonstrated the potential value of phenomenological research.

2.7 References

- Alexander, C., & Charles, G. (2009). Caring, mutuality and reciprocity in social worker-client relationships. *Journal of Social Work*, 9(1), 5-22.
- Bailey, K. (2008). *Methods of Social Research* (4th edn.). New York: The Free Press.
- Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., & Whelton, B. (2010). Adult protection of people with intellectual disabilities: Incidence, nature and responses. *Journal of Applied Research in Intellectual Disabilities*, 23, 573-584.
- Biggerstaff, D. L., & Thompson, A. R. (2008). Interpretive Phenomenological Analysis (IPA): A qualitative method of choice in healthcare research. *Qualitative Research in Psychology*, 5, 173-183.
- Bland, R. E. (1997). Keyworkers re-examined: Good practice, quality of care and empowerment in residential care for old people. *British Journal of Social Work*, 27, 585-603.
- Buckinghamshire County Council (1998). *Independent Longcare Inquiry*. Buckingham: Buckinghamshire County Council.
- Butterworth, T., Bell, L., Jackson, C., & Pajnkihar, M. (2008). Wicked spell or magic bullet? A review of the clinical supervision literature 2001-2007. *Nurse Education Today*, 28, 264-272.
- Cambridge, P. (1999). First hit: A case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability & Society*, 14(3), 285-305.
- Care Quality Commission (2012a). *The State of Health Care and Adult Social Care in England in 2011/12*. London: The Stationary Office.
- Care Quality Commission (2012b). *Learning Disability Services Inspection Programme: National Overview*. Newcastle: The Care Quality Commission
- Cavendish, C. (2013). *The Cavendish Review: An Independent Review into Healthcare Assistants and Support Workers in the NHS and Social Care Settings*. London: Department of Health.
- Conlie-shaw, M. M. (1998). Nursing home resident abuse by staff: Exploring the dynamics. *Journal of Elder Abuse & Neglect*, 9(4), 1-21.
- Dabos, G. E., & Rousseau, D. M. (2004). Mutuality and reciprocity in the psychological contracts of employees and employers. *Journal of Applied Psychology*, 89(1), 52-72.
- Department of Health (2012). *Transforming Care: A National Response to Winterbourne View Hospital*. London: Department of Health.

- Donovan, R. J., Holman, C. D., Corti, B., & Jalleh, G. (1997). Face to face household interviews versus telephone interviews for health surveys. *Australian & New Zealand Journal of Public Health*, 21(2), 134–140.
- Duffy, B., Oyebode, J. R., & Allen, J. (2009). Burnout among care staff for adults with dementia: The role of reciprocity, self-efficacy and organisational factors. *Dementia*, 8(4), 515-541.
- Furey, E. M. (1989). Abuse of persons with mental retardation: A literature review. *Behavioral Residential Treatment*, 4(2), 143-154.
- Glaser, B. G., & Strauss, A. L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New York: Aldine de Gruyter.
- Goergen, T. (2004). A multi-method study on elder abuse and neglect in nursing homes. *Journal of Adult Protection*, 6(3), 15-25.
- Greenfield, T. K., Midanik, L. T., & Rogers, J. D. (2000). Effects of telephone versus face to face interview modes on reports of alcohol consumption. *Addiction*, 95 (2), 277–284.
- Hastings, R. P. (2010). Support staff working in intellectual disability services: The importance of relationships and positive experiences. *Journal of Intellectual and Developmental Disability*, 35(3), 207-210.
- Healthcare Commission (2007). *Investigation into the Service for People with Learning Disabilities Provided by Sutton and Merton Primary Care Trust*. Healthcare Commission: London.
- Hyrkas, K., Koivula, M., Lehti, K., & Paunonen-Ilmonen, M. (2003). Nurse managers conceptions of quality management as promoted by peer supervision. *Journal of Nursing Management*, 11, 48-58.
- Jones, A. (1999). Clinical supervision for professional practice. *Nursing Standard*, 14, 42-44.
- Mansell, J. (2006). Deinstitutionalisation and community living: Progress, problems and priorities. *Journal of Intellectual & Developmental Disability*, 31(2), 65-76.
- Marsland, D., Oaks, P., & White, C. (2007). Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings. *Journal of Adult Protection*, 9(4), 6-20.
- Mickan, S. M., & Rodger, S. A. (2005). Effective healthcare teams: A model of six characteristics developed from shared perceptions. *Journal of Interprofessional Care*, 19(4), 358-370.
- Moore, D. (2001). Friend or foe? A selective review of literature concerning abuse of adults with learning disability by those employed to care for them. *Journal of Learning Disabilities*, 5(3), 245-258.

- Nix, G., Ryan, R. M., Manly, J. B., & Deci, E. L. (1999). Revitalization through self-regulation: The effects of autonomous and controlled motivation on happiness and vitality. *Journal of Experimental Social Psychology*, 35, 266-284.
- Olubokun, J. (2007). Development of learning disability services in the West Yorkshire region. *The British Journal of Developmental Disabilities*, 53, 125-130.
- Payne, B. K., & Cikovic, R. (1995). An empirical examination of the characteristics, consequences and causes of elder abuse in nursing homes. *Journal of Elder Abuse and Neglect*, 7(4), 61-74.
- Pennycook, M. (2013). *Does it Pay to Care? Under-payment of the National Minimum Wage in the Social Care Sector*. London: Resolution Foundation.
- Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, 29(3), 314-320
- Pillemer, K., & Moore, D. W. (1990). Highlights from a study of abuse of patients in nursing homes. *Journal of Elder Abuse and Neglect*, 2(1/2), 5-29.
- Rohde, P., Lewinson, P. M., & Seeley, J. R. (1997). Comparability of telephone and face-to face interviews in assessing axis 1 and 2 disorders. *American Journal of Psychiatry*, 154(11), 1593–1598.
- Rose, J., Madurai, T., Thomas, K., Duffy, B., & Oyebode, J. (2010). Reciprocity & burnout in direct care staff. *Clinical Psychology & Psychotherapy*, 17, 455-462.
- Rusch, R. G., Hall, J. C., & Griffin, H. C. (1986). Abuse provoking characteristics of institutionalised mentally retarded individuals. *American Journal of Mental Deficiency*, 90(6), 618-624.
- Ryan, R. M., & Deci, E. L. (2000). Self-Determination Theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68-78.
- Sheldon, K. M., Ryan, R. M., Rawsthorne, L., & Ilardi, B. (1997). Trait self and true self: Cross-role variation in the big five traits and its relations with authenticity and subjective well-being. *Journal of Personality & Social Psychology*, 73, 1380-1393.
- Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretive phenomenological analysis in health psychology. *Psychology & Health*, 11, 261-271.
- Smith, J. A., & Osborn, M. (2008). Interpretative Phenomenological Analysis. In J.A. Smith (ed). *Qualitative Psychology: A Practical Guide to Methods* (2nd edn). London: Sage.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory Method and Research*. London: Sage.
- Stanley, N., Manthorpe, J., & Penhale, B. (Eds.). (1999). *Institutional Abuse: Perspectives Across the Life course*. London: Routledge.

- Thane, P. (1978). *The Origins of British Social Policy*. London: Croom Helm.
- Thomas, C., & Rose, J. (2010). The relationship between reciprocity and the emotional and behavioural responses of staff. *Journal of Applied Research in Intellectual Disabilities*, 23, 167-178.
- Van Horn, J. E., Schaufeli, W. B., & Taris, T. W. (2001). Lack of reciprocity among Dutch teachers: Validation of reciprocity indices and their relation to stress and wellbeing. *Work and Stress*, 15(3), 191-213.
- Van Loon, J., & Van Hove, G. (2001). Emancipation and self-determination of people with learning disabilities and down-sizing institutional care. *Disability & Society*, 16(2), 233-254.
- Wang, J. (2005). Psychological abuse behavior exhibited by caregivers in the care of elderly and correlated factors in long-term care facilities in Taiwan. *Journal of Nursing Research*, 13(4), 271-280.
- Wardhaugh, J., & Wilding, P. (1993). Towards an explanation of the corruption of care. *Critical Social Psychology*, 37, 4-31.
- White, C., Holland, E., Marsland, D., & Oaks, P. (2003). The identification of environments and cultures that promote the abuse of people with intellectual disabilities: A review of the literature. *Journal of Applied Research in Intellectual Disabilities*, 16, 1-9.
- White, E., & Winstanley, J. (2010). Does clinical supervision lead to better patient outcomes in mental health nursing? *Nursing Times*, 106, 16-18.
- White, E., Butterworth, T., Bishop, V., Carson, J., Jeacock, J., & Clements, A. (1998). Clinical supervision: Insider reports of a private world. *Journal of Advanced Nursing*, 28, 185-192.
- Zirpoli, T. J., Snell, M. E., & Lloyd, B. H. (1987). Characteristics of persons with mental retardation who have been abused by caregivers. *Journal of Special Education*, 21(2), 31-41.

3. Public Domain Briefing Paper

3.1 Introduction

3.1.1 What is this about?

This document summarises a research study, which explored possible reasons and explanations for varying standards of care within residential services for adults with learning disabilities. Firstly, it describes a literature review that looked at what existing research tells us about the causes of abuse and neglect in adult residential care services. Secondly, a piece of research is described, which examined care staff members' experiences of working in residential homes and services for adults with learning disabilities.

3.1.2 Why was this research done?

This research formed part of the authors training to be a clinical psychologist. Specifically, when clinical psychologists train they are required to undertake a piece of research in an area that is relevant to clinical practice.

3.2 Literature Review

3.2.1 What is a literature review?

Literature reviews attempt to summarise all the research that has been conducted in a particular area. Therefore, they are a useful way of finding out what we know and what we don't know about a specific research area or question. This literature review attempted to find out about what we currently know about the causes and risk factors associated with abuse and neglect in residential care facilities.

3.2.2 Why was it necessary to conduct this review?

In recent years there have been a number of high profile cases of substandard care and abuse in adult residential care services. This has raised concerns about the quality of care and support that adults living in these services are receiving. In response to these concerns, research has been conducted to explore the range of possible causes of substandard care and

abuse. However to date, no attempts have been made to summarise or provide an overview of the existing research.

3.2.3. What was the aim of the literature review?

Therefore, the aim of this literature review was to summarise research that has attempted to identify causes and risk factors associated with abuse and neglect in residential care facilities for adults.

3.2.4 How was the review conducted?

To identify relevant research articles, electronic searches of internet databases were carried out alongside hand searches of the following journals: *Journal of Elder Abuse*; *Journal of Adult Protection*. To be included in the review, studies were required to be published in English language journals and describe research aimed at identifying or exploring causes or risk factors associated with abuse or neglect in residential care services. Articles also had to be about the residential care of adults (aged 18+) within physical health, mental health or learning disability services. Where suitable articles were identified, specific details were extracted from them, which were then presented to create a summary of research in this area.

3.2.5 What did the review reveal?

Based on the above process 15 articles were found. They revealed that a range of different methods and approaches have been used to explore possible reasons why abuse and neglect occur within residential services. Of the fifteen studies, 11 focussed on the abuse or neglect of older adults in care and the remaining 4 focussed on the abuse of adults with learning disabilities. Therefore, no research was found that has explored the causes of abuse and neglect in other services (e.g. those for people with physical or mental health related difficulties). Causes and risk factors were separated into those that were about the culture or care environment and those that were about the individual characteristics of service users or staff members. Some of the common cultural or environmental causes or risk factors included:

low staffing levels, services that were isolated, a lack of staff support/supervision, intimidating environments and large services. Some of the common causes or risk factors relating to individual characteristics included: inexperienced staff members, emotional stress/exhaustion in staff, physical aggression from residents, negative staff attitudes towards residents, residents with limited verbal abilities and residents who were limited in their activities of daily living.

Although this study did acknowledge that research into abuse and neglect can be difficult to conduct, the results of the review also revealed that the quality of research in this area is limited. Specifically, because of the methods that were used, it is difficult to draw firm conclusions from the data presented.

3.2.6 What conclusions were drawn from the review?

Although the issue of substandard care and abuse in residential adult services has been well documented, research in this area is still underdeveloped. Therefore, there is a need for further high quality research to be conducted in order to better understand the different factors that can influence care standards. However, this review has provided a useful summary of research in this area, which highlights the potentially complex range of factors linked to the abuse and neglect of adults in residential care. Ultimately it is hoped that this will help prompt further research in this area, which will ultimately lead to improvements in residential care standards and a reduction in future instances of abuse and neglect.

3.3 Research Paper

3.3.1 Why was this piece of research done?

Within the last 25 years, changes to services for people with learning disabilities have resulted in more people being cared for at home or in the community, as opposed to in large scale, residential homes or hospitals. However, due to the fact that some people's complex needs require intensive support, inpatient facilities and group homes still exist to ensure that those

with complex needs get the right level of care. Despite the specialist nature of today's residential services, evidence suggests that the standards of care they provide can vary greatly. Although some research has attempted to understand this, there is a clear need for more research in this area. Previous research has also not considered the potentially valuable perspective that the care staff, who work in residential services for people with learning disabilities, may be able to provide.

3.3.2 What was the aim of this research?

Therefore, the aim of this research was to explore staff members' experiences of working in residential care for people with learning disabilities.

3.3.3 How was this research conducted?

Six care workers (4 female, 2 male), with extensive experience of working in residential services, were interviewed about their work roles. Interview data was analysed using an approach called Interpretive Phenomenological Analysis (IPA). This attempts to identify themes from the interview data, which reveal what it might be like to work in residential services for people with learning disabilities.

3.3.4 What was found?

The following three main themes were identified as important features of participants' experiences of their work: 1. *Degree of Positive Relationship Reciprocity*; 2. *Value Congruence and Intrinsic Motivation*; 3. *Experiences of Environmental and Organisational Constraints*. The first of those themes captures how important relationships with others at work can be. Specifically, the results suggested that it was important for staff to be able to feel like they were getting something back from their relationships with service users, colleagues or the organisations they worked for. This might include getting a sense of achievement or pleasure from interactions with service users, getting emotional support and respect from colleagues or getting a sense that they are valued by their managers. The second theme

captured the extent to which participants experienced their work role as being consistent with their values and priorities as a person. Specifically, the results suggested that this can vary from person to person and is likely to also impact on their commitment to their job. Finally, the third theme referred to things to do with the environment or organisation participants worked in, that were experienced as being restrictive or challenging in some way. This included the extent to which participants felt that the services they worked in were isolated from mainstream society. Where participants did have experiences of working in isolated services, this was not considered a positive experience. Participants also described experiencing varying standards of leadership and guidance while in their work roles.

3.3.5 What conclusions were drawn from this study?

The results of this study complement existing research in this area by providing additional insight into the factors that can influence care standards in residential services. Specifically, it has highlighted that variations in the nature of people's interpersonal relationships may impact on care practices. As a result strategies and techniques need to be considered, which address the perceived equality of care staffs' relationships with their employing organisation, their work colleagues and the service users they work with. It has also highlighted that care standards can be impacted on by people's motives for working in care and the extent to which it is the type of work that suits them as a person. Therefore, when recruiting care staff, organisations may need to pay greater attention to individual staff motives and characteristics. Ultimately, it is hoped that this research has contributed to a greater understanding of staff experiences and care practices in residential services, which can go on to inform future research and applied practices.

Appendices

Appendix A: Instructions to Authors from Nominated Journals

[Removed for copyright reasons]

Appendix B: Empirical Paper

Appendix B.1: Confirmation of Ethical Approval Email

[Removed to preserve confidentiality]

INFORMATION SHEET

Title of Project:

Making sense of varying standards of care: Front-line staff experiences of working in residential care environments for adults with learning disabilities.

Researchers:

My name is Andrew Hutchison. Thank you for expressing an interest in being part of the above research project. This project is being undertaken as part of my clinical psychology doctoral training under the supervision of Dr ??? ????? (senior lecturer).

• ***What is the aim of this research?***

We want to explore how front-line care staff of residential services for people with learning disabilities, experience their work and make sense of care standards and practices. We are interested in understanding what it is like to work as a member of staff in a residential service for adults with learning disabilities.

• ***Why have I been invited to take part?***

We have invited you to take part in this research project because you are working or have previously worked in a residential service for adults with learning disabilities. We would be very interested in hearing about your work experiences.

• ***What will happen if I agree to take part?***

If you agree to take part, we will ask you to indicate this by reading and signing the enclosed consent form and returning it to me in the stamped addressed envelope provided. You will also be asked to complete the enclosed participant details form and tell us how you would like to be contacted. I will then arrange a face to face or telephone interview (depending on your preference). Interviews will be conducted by me, will last for approximately one hour and will focus on exploring your experiences of working in residential services for people with learning disabilities. Although you will be encouraged to talk freely about your experiences, what you choose to talk about is entirely up to you. There will be no expectation for you to discuss anything that you feel uncomfortable talking about.

Interviews will all be recorded and transcribed. Digital voice recordings and word processed interview transcripts will be held by me at the University of Birmingham. All data files will be anonymised and password-protected. The only personal data collected will be demographic

information (i.e. age, gender, job title, years of experience), which will be used to describe the sample of people who chose to take part and will not be linked to individual interview transcripts. This information will be collated and stored separately to the interview transcripts in a locked filing cabinet.

Transcripts will remain confidential (between myself, interviewee & academic supervisor) and your anonymity (and the anonymity of any employers) will be preserved. If you mention anything during the course of the interview that raises concerns about the safety of yourself or others, then I may be required (after discussing it with yourself) to break confidentiality.

- ***What will happen if I do not want to carry on with the study?***

You are free to withdraw your consent to participate, without providing any reason, and this will not have any negative consequences. To allow for this, you will be given a two-week period for reflection after the interview, after which I will be in contact to remind you that you can withdraw your interview entirely or in part without giving any reason and without consequences. If you do decide to withdraw your consent after taking part in an interview, the interview transcript will not be included in the analysis and transcript/digital recording will be deleted or destroyed. If you do not withdraw your consent after the two-week reflection period, your interview will be included in the data analysis.

- ***What will happen to the results of the research study?***

Results of this study will be written up for publication, in an academic journal, which forms part of the assessment of my clinical psychology training. Where direct quotations are published, these will remain anonymous and will contain no identifying information. On request a written summary of the results can be provided for all participants, once the research is complete. If you do consent to take part and would like to receive a written summary of the findings, please indicate this on the enclosed form.

- ***What happens if I have any further concerns?***

If you have any further concerns or if you would like to discuss any aspect of this research please contact myself:

Andrew Hutchison or [Removed for confidentiality]

Tel: [Removed for confidentiality] [Removed for confidentiality]

Email: [Removed for confidentiality] [Removed for confidentiality]

Post: [Removed for confidentiality]

Appendix B.3: Consent Form

Research site:

Participant Identification Number:.....

CONSENT FORM

Title of Project: Making sense of varying standards of care: Front-line staff experiences of working in residential care environments for adults with learning disabilities.

Researcher: Andrew Hutchison

Please initial box

1. I confirm that I have understood the information sheet dated (version ...) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily if appropriate. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason and without any negative consequences on my behalf. ☐
3. I understand that the research interview will be audio-recorded ☐
4. I understand that following the research interview I will have a two-week period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason. ☐
5. I understand that the data collected during this study will only be looked at by the researcher and his academic supervisor at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data. ☐
6. I understand the limits to confidentiality and that in the event of me discussing experiences that raise concerns about the safety of myself or others, that the researcher may need to disclose details to third parties, in order to put in place appropriate safeguarding procedures. ☐
7. I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any such quotes and that I or my place of work will not be identifiable by my comments. ☐
8. I agree to take part in the above study. ☐

.....
Name of participant

.....
Date

.....
Signature

.....
Name of researcher

.....
Date

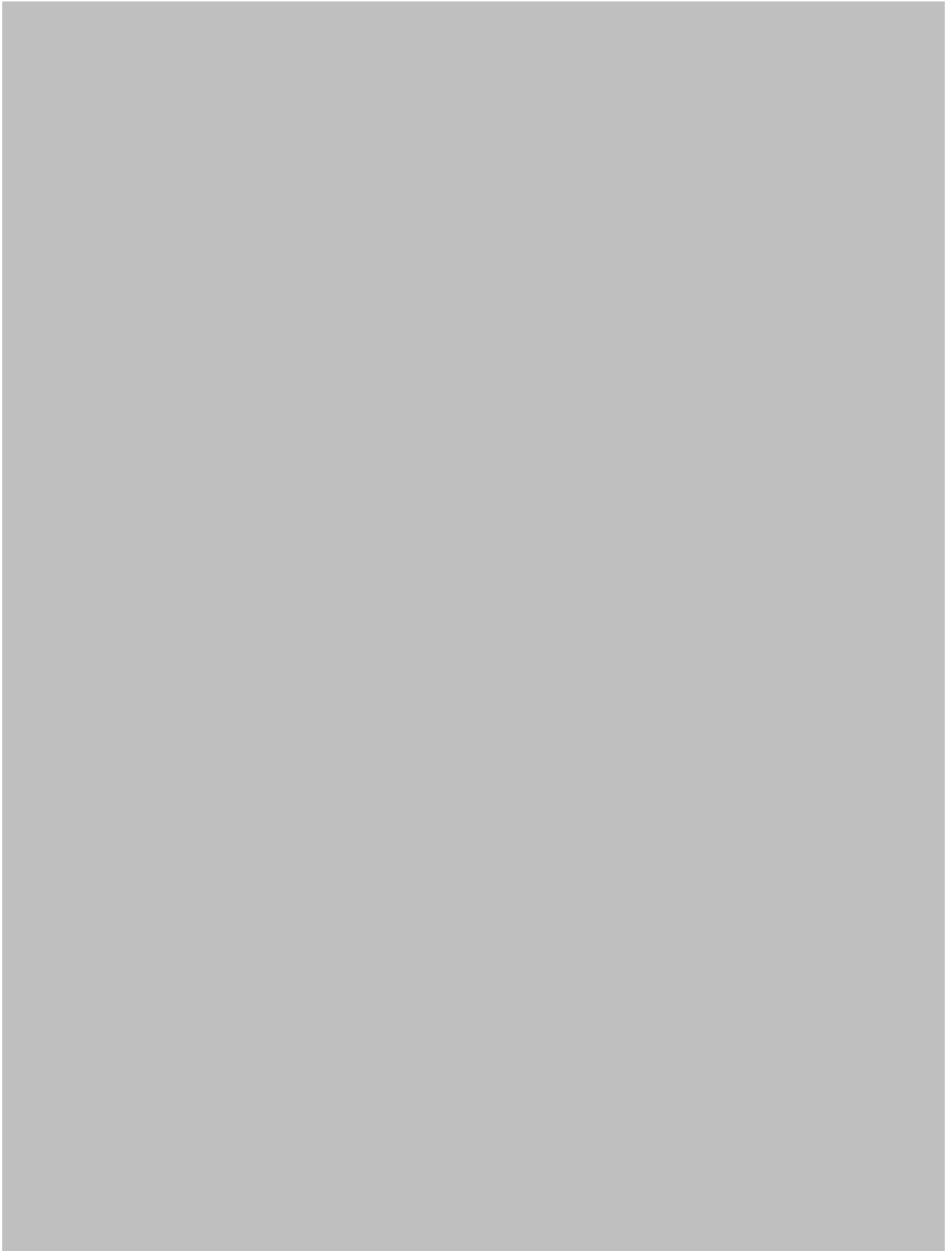
.....
Signature

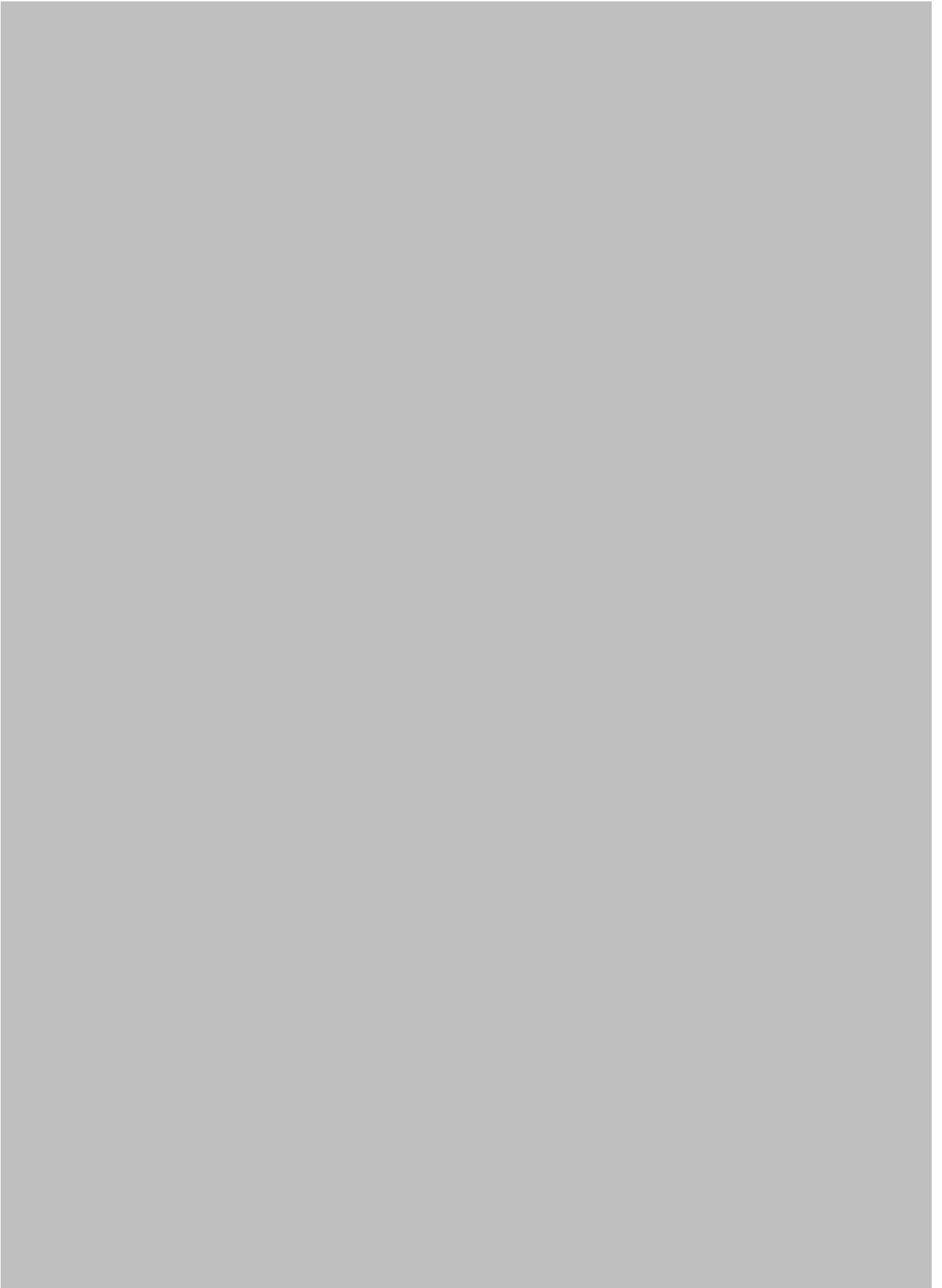
Appendix B.4: Interview Schedule

1. Without saying where you have worked or providing names of services/organisations, could you briefly describe what experiences you have had of working in residential learning disability services to date?
 - Prompts: Type of service? Client group? Timescales?
2. Could you describe what your main roles and responsibilities have been in that work?
 - Prompts: What do you do? Typical day? What did you enjoy most? What did you enjoy least?
3. If I asked you why you chose to pursue a career in care work or what things prompted you to get the jobs you have mentioned what would you say?
 - Prompt: What do this type of work mean to you?
4. In the time that you have been working in residential services for people with learning disabilities, what changes have you experienced?
 - Prompts: What have you noticed? Did work feel different, if so how? Care delivery practices? Changes in standards? Training? Processes and procedures?
5. Based on your experiences, what has the impact of those changes been?
 - Prompts: How has it changed your roles/responsibilities? How has it impacted on your own attitudes/morale? How have changes impacted on care standards/service users?
6. What challenges did you or do you encounter at work?
 - Prompts: What makes them challenging? How do you overcome them?
7. What do the terms “quality care” and “good practice” mean to you?
 - Prompts: How do you know that what you are doing is good quality or good practice?
8. From your experiences, what do you see as the main barriers to quality care/good practice?
9. Is there anything else you would like to say about your experiences of working in residential care for people with learning disabilities?

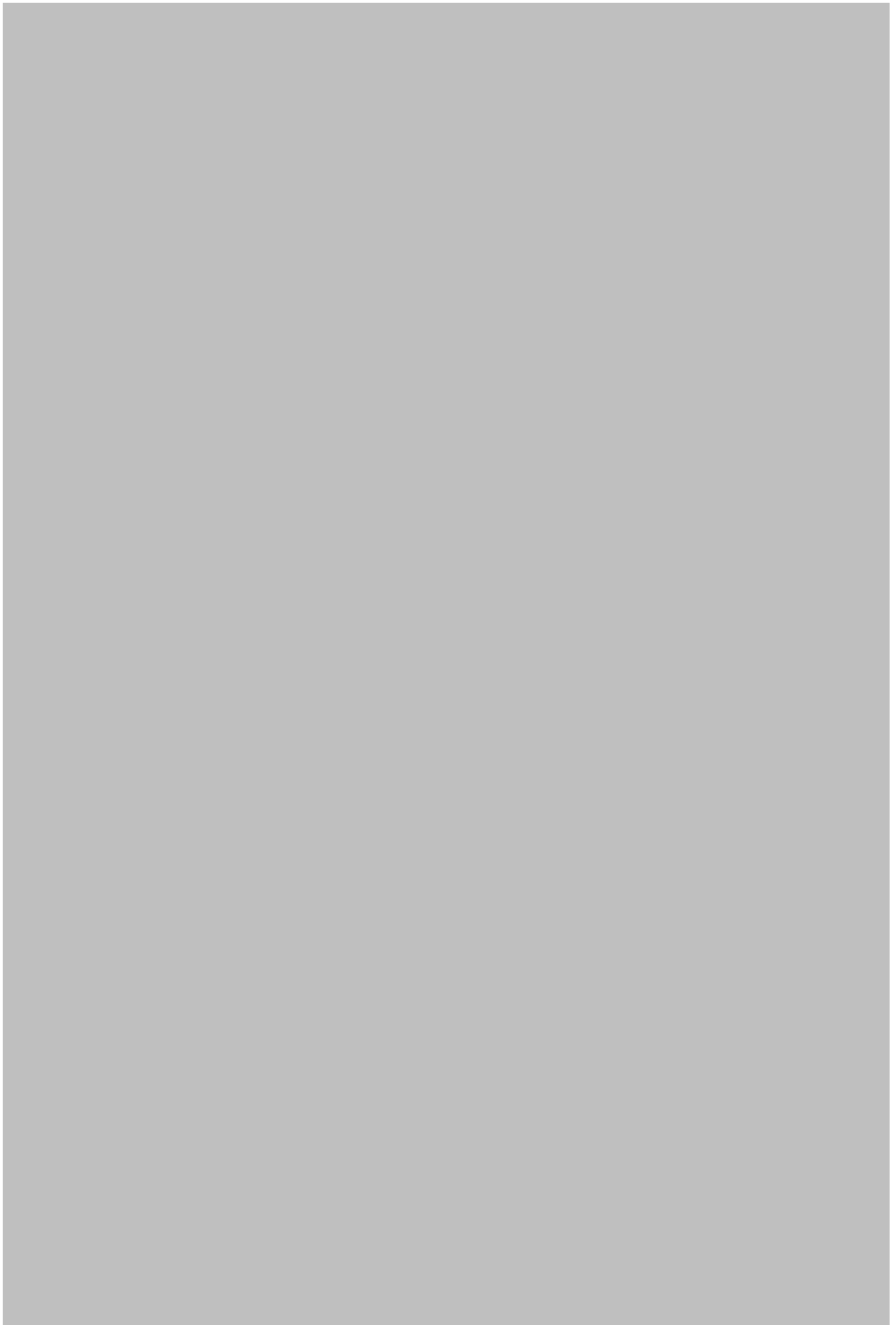
Appendix B.5: Extract from Annotated Transcript

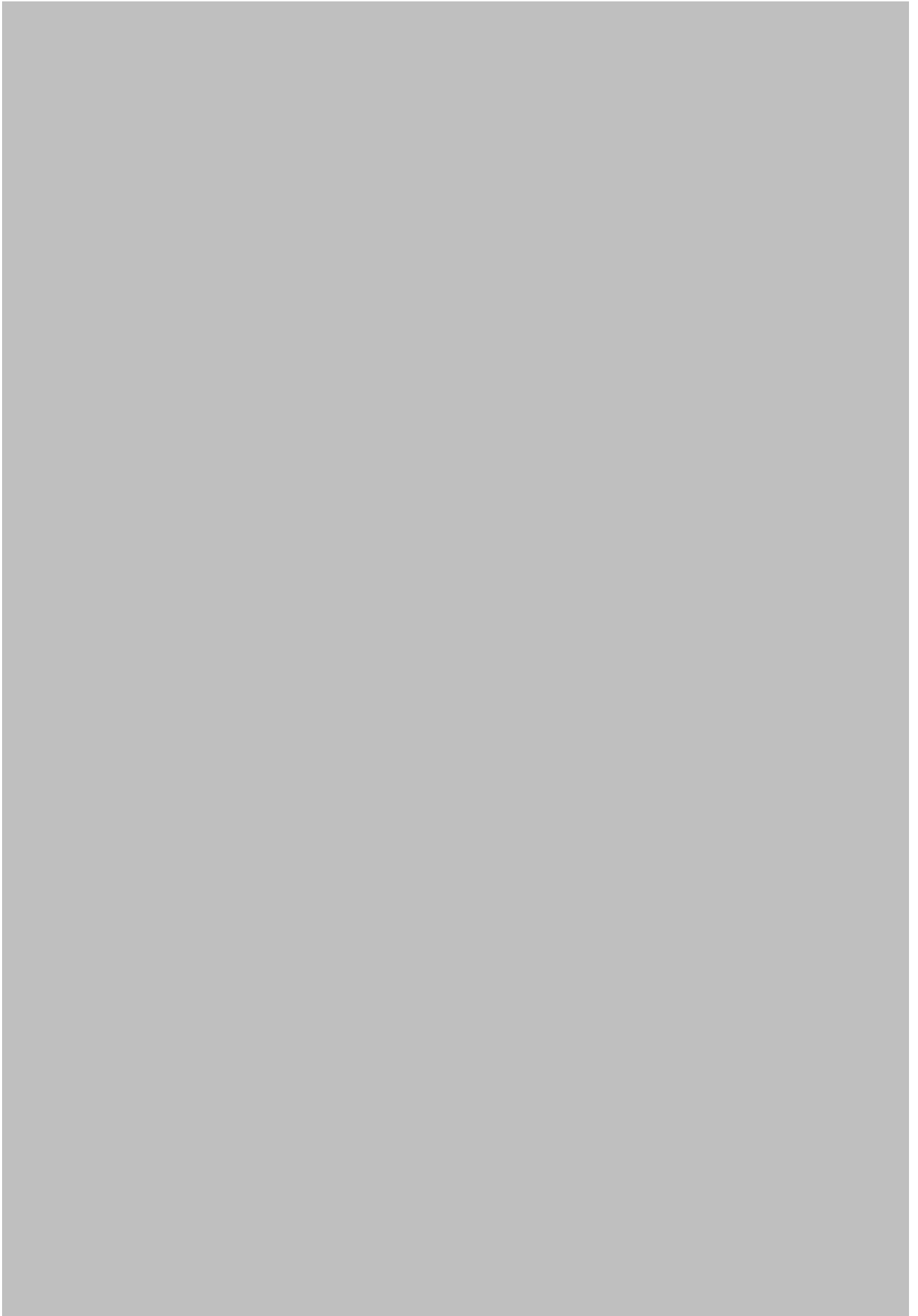
Interview 3 (TC)













Appendix B.6: Extract from Analytical Process Document

Description of Analytical Process Document

Identifying Themes in the First Case:

The first interview transcript was read a number of times and annotated to highlight significant or interesting themes within the text. Due to the fact that this study was concerned with understanding the lived experiences of the participants involved, initial notes/comments typically represented observations or preliminary interpretations, which it was felt provided insight into this phenomenon. Having annotated the first transcript (in the left-hand margin), the initial notes were subsequently transformed into more concise themes or phrases (in the right-hand margin), which it was felt captured the essential quality of what had been identified within the text. Emergent themes were then clustered according to observed relationships between them. To facilitate the clustering of themes and identification of potential relationships, colour categories were assigned to themes that appeared to be related to one another. The table below summarises the initial themes and associated cluster categories in list form.

Case 1: Initial list of themes organised into colour coded related clusters.

| Theme | Frequency |
|---|------------------|
| Awareness of organisational structure | 1 |
| Awareness of impact of organisational factors | 1 |
| Importance of providing personalised care | 1 |
| Developing relationships | 1 |
| Familiarity | 3 |
| Relational closeness (to residents) | 4 |
| Recognising freedom of choice | 1 |
| Awareness of environmental factors | 1 |
| Delighting in work achievements | 2 |
| Championing residents sense of agency | 1 |
| Valuing equality | 2 |
| Feeling part of a team | 2 |
| Collaborative relationships (with residents) | 1 |
| Valuing facilitating choice | 1 |
| Respecting individual differences | 1 |
| Shared (team) values | 2 |
| Intuitive care | 3 |
| Congruence with personal values | 2 |
| Enjoyment/pleasure | 6 |
| Shared enjoyment | 1 |
| Shared experiences | 1 |
| Sense of community | 1 |
| Team working | 1 |
| Valuing individual differences | 4 |
| Acceptance of systems & procedures | 1 |
| Perceiving workload/responsibilities as appropriate | 1 |
| Powerlessness | 1 |
| Having a voice | 1 |
| Variety | 1 |

| | |
|--|---|
| Motivated to care for others | 5 |
| Relational closeness (to colleagues) | 4 |
| Intrinsically valuing work | 1 |
| Emotionally attached | 2 |
| Sense of achievement | 1 |
| Facilitating sense of choice | 1 |
| Feeling valued | 5 |
| Collaborative care planning | 2 |
| Feeling cared for | 5 |
| Confidence to express views | 1 |
| Freedom of expression | 2 |
| Acceptance of policies/procedures | 1 |
| Shared culture of care | 1 |
| Valuing quality of life of others | 2 |
| Valuing mutual respect | 1 |
| Respecting individual needs | 1 |
| Advocating mutual respect | 1 |
| Prioritise care responsibilities | 1 |
| Relational closeness (with management) | 1 |
| Security/supported | 1 |
| Championing sense of autonomy | 1 |
| Feeling protected | 1 |
| Collaborative decision making | 1 |
| Shared philosophy of care | 1 |

Connecting Themes in the First Case:

Having created a list of initial themes and identified possible clusters/relationships, superordinate categories were then defined in order to make sense of the emergent connections. At first this involved re-arranging the themes in the table, so that those coded to the same colour were together. Having done this, each colour category was explored in more detail and an attempt was made to define or describe what they had in common. This process was iterative in nature, because as clusters and superordinate categories emerged, these were constantly checked with the source material to ensure that interpretations remained grounded in and accurately representative of the data collected. The results of this process are depicted in the table below, which identifies 10 theme clusters generated from the initial list of first order themes.

Summary table of themes from first case.

| | Theme | Relevant Example Quotes |
|---|--|--|
| 1 | <i>Relational Closeness/Relational Needs</i> | |
| | <ul style="list-style-type: none"> - Developing relationships - Relational closeness (to residents) - Feeling part of a team - Collaborative relationships (with residents) - Shared enjoyment - Shared experiences - Relational closeness (to colleagues) - Emotionally attached - Relational closeness (with management) - Familiarity | <p>"...they can, they get used to you and you become closer to the residents and it's so much different...it's much much better. For my experiences as well and for the residents it is better" [1.40]</p> <p>"...you have this bond of course. Professional relationships with the residents. But you get to know them better and you know their needs much better" [1.52]</p> <p>"And to have, you know, we're the staff. But it is impossible to not have that bond and to have like a small family type of thing" [1.185]</p> <p>"I have got really close, and the relationships we have with colleagues are really close" [1.295]</p> <p>"it would break my heart If I had to leave" [1.266]</p> <p>"the manager knows what's going on with you if you perhaps don't look happy. That's why you create a close relationship with them" [1.485]</p> <p>"they get used to you, you become closer" [1.58]</p> |
| 2 | <i>Team working</i> | |
| | <ul style="list-style-type: none"> - Shared (team) values - Collaborative care planning - Shared culture of care - Collaborative decision making - Shared philosophy of care - Acceptance of systems & procedures - Perceiving workload/responsibilities as appropriate - Acceptance of policies/procedures | <p>"we have a very healthy lifestyle, when it comes to food" [1.145]</p> <p>"We are always asked to staff meetings, we can bring our concerns; we can, err, bring new ideas because we work every day with the residents. And the managers will take everything on board and make some changes if it is necessary, to the care plans. They always listen to us" [1.548]</p> <p>"the care or quality of care comes down to how the house or place is run" [1.376]</p> <p>"I don't mind the paperwork. It comes with the job Anything that is necessary" [1.198]</p> <p>"I don't personally mind those jobs" [1.211]</p> <p>"I don't mind the paperwork. So daily we have to fill in folders.... It comes with the job Anything that is necessary" [1.198]</p> |
| 3 | <i>Supported, Secure & Valued</i> | |
| | <ul style="list-style-type: none"> - Sense of community - Having a voice - Feeling valued - Feeling cared for - Confidence to express views - Freedom of expression - Security/supported - Feeling protected | <p>"...you feel very much part of a little community or family" [1.180]</p> <p>"...and the managers will take everything on board" [1.551]</p> <p>"...they [the managers] always listen to you" [1.552]</p> <p>"yes, feeling free to talk about your problems and not just keep them in" [1.494]</p> <p>"we're more open and you don't feel bad to mention things you are not happy with" [1.362]</p> <p>"...you have someone to talk to ... and don't have to pretend everything is ok" [1.485]</p> <p>"we are very well supported, very very" [1.532]</p> |

| | | |
|----|---|--|
| 4 | <i>Values: Working Respectfully with Individual Differences</i> | <p>"so it's possible to give greater attention and personalised support" [1.17]</p> <p>"...because they have feelings, they feel the need to be accepted, loved and cared for. So this is what we provide for all their needs" [1.188]</p> <p>"yes, we will help them with personal care depending on their needs" [1.141]</p> <p>"I personally find it difficult when people are very judgemental" [1.218]</p> <p>"and it's the same with the residents. We have to keep the confidentiality and respect that" [1.431]</p> |
| 5 | <i>Congruence with personal values</i> | <p>"I feel like I am making a difference... And if I do this job, I feel like 'yes, I've done something good today' and I maybe changed someone's life for one day" [1.300]</p> <p>"it's just common sense when it comes to personal care" [1.154]</p> <p>"we get to involve the residents in activities. For example, I love singing" [1.162]</p> <p>"some paperwork is enjoyable [Laughs]" [1.208]</p> <p>"I really wanted this challenge of working with people and for people" [1.245]</p> <p>"I'm enjoying my job very much ... and that's something I want to hang on to" [1.275]</p> <p>"it's not just my job, it's p[art of who I am" [1.301]</p> |
| 6 | <i>Values: Autonomy and Freedom of Choice</i> | <p>"even though it's a residential house, it is their choice, we try to give them their choice ... whatever" [1.101]</p> <p>"so it's important to give them as many activities as possible" [1.132]</p> <p>"so we try to give them as many activities as possible" [1.119]</p> <p>"so they had the feeling it was their house" [1.91]</p> |
| 7 | <i>Values: Striving for equality</i> | <p>"...us, as support workers, would try to give them as much independence and normal life and freedom of choice, and being able to live as everyone else and have the same choices in life, and have a normal life" [1.78]</p> <p>"I have my choice, so they have a right to choose" [1.115]</p> <p>"...if I walked into a house where it is a mess. The residents are not very well looked after, they don't clean, um, for me that doesn't show me that they have good quality of life and of care" [1.387]</p> <p>"I personally find it difficult when people are very judgemental" [1.218]</p> <p>"I try to treat them as I would like to be treated" [1.438]</p> |
| 8 | <i>Power Imbalances</i> | <p>"...you can't say anything, you just have to carry on" [1.235]</p> |
| 9 | <i>Organisation/Environment</i> | <p>"I can see the difference in how residents are treated in small environments" [1.13]</p> <p>"there was such a difference when people had moved (to a different living environment)" [1.84]</p> |
| 10 | <i>Stimulation vs Boredom</i> | <p>"doing the same job every day. I found that really boring" [1.244]</p> |

